Eye Care Associates
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Drs. Thomas E. McCarthy, Jason C. Eubank,
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Authorization for Release of Identifying Health Information

PATIENT NAME

PATIENT NUMBER

PATIENT PHONE NUMBER

PATIENT ADDRESS

PATIENT DATE OF BIRTH

I authorize the professional office of my optometrist named above to release health information identifying me under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released:

3. The purpose(s) for the release:

4. Expiration date or event relating to the individual or purpose for the release: 365 days from the date entered below.

It is completely your decision whether or not to sign this authorization for. We cannot refuse to treat you if you choose not to sign the authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, sate or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

SIGNATURE

DATE

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

RELATIONSHIP TO PATIENT

PRINT NAME

SOURCE OF AUTHORITY

ADDRESS

PHONE NUMBER