Northwest Eye Care Professionals

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Authorization to release Medical Information:

Last Name:________________________________ First: _______________________________ MI:________

DOB: _______________ Phone number: _________________________

Address: ____ State_______ Zip code: _____________

At my request, I authorize:	**To make disclosure to**:
Practice name:_________________________________	*Practice name*: ________________________________
Address:_______________________________________	*Address*:______________________________________
____	____
Phone: _________________ Fax: __________________	Phone: _________________ Fax: __________________

Specifically, I authorize the use or disclosure of the following information: (please initial)

____ Complete record ___ VT chart notes
____ Chart notes ___ Other _________________________
____ Diagnostic Records ___ Other _________________________

Please list specific dates: ________________________________ or **All records** _____________

If my records contain the following information, it is also released if CHECKED in boxes below:

HIV/AIDS information Mental health information Genetic testing information Drug/Alcohol information

Statement of understanding:

- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.
- I understand and acknowledge that this authorization extends to use and/or disclosure from my medical records which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS, and/or may include results of an HIV test or the fact that an HIV test was performed.
- You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.
- This authorization is valid for 180 days, unless otherwise revoked by written notice. This does not apply to information already used or disclosed in response to this authorization.
- You may inspect or copy the protected health information to be disclosed or used under this authorization.

Signature of Patient/Personal Representative: ____

Relationship to Patient: ____________________ Date: __________________________