Front Range EYE Associates
Excellence You Can See

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name: _____

Patient current address: _____

Patient previous address: (if applicable) _____

Patient phone number: (_____)_____

Patient DOB: _____/_____/_____

I authorize the professional office of my optometrist named above to release the specific health information described below identifying me (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) only for the purposes and parties described below under the following terms and conditions:

- Description of the specific information to be released; ☐ MEDICAL , ☐FINANCIAL , and/or ☐ OTHER (specify) _____☐ CL Rx and History ☐ Spectacle Rx and History
- Information may be released TO the following persons or entities; **Front Range Eye Associates, P.C. ATTN: ☐ Dr. Murphy or ☐ Dr. Pipkin**
- Information to be released for the following purpose(s); ☐ CONTINUITY OF CARE or ☐ _____
- Authorization will remain in effect from the date signed below until the specified expiration date _____/_____/_____ or ☐ NO EXPIRATION DATE.

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

If you sign this authorization, you can revoke it later. The exceptions to this are 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 address listed above.

We will not receive a financial benefit from disclosing health information about you.

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

Patient Signature: _____ Date:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____ Print Name: _____

Source of Authority: _____

CLINIC USE:
Dr Review Notes: _____
_____
FU w/ PT: ☐ Y ☐ N ☐ Phone ☐ Email

OFFICE USE:
TO: _____ P: _____
1st: _____ 2nd: _____ F: _____
Staff Initials 1st : ____ 2nd : ____