
REQUEST FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

INFORMATION TO BE DISCLOSED:

- Record of last exam including spectacle prescription and contact lens prescription
- Entire record

PRACTICE FROM WHICH INFORMATION IS REQUESTED:

Name of Practice: _____

Practice Address: _____

Phone Number: _____ Fax: _____

RECIPIENT:

Name and address of person or class of persons to whom the Practice may disclose my health information:

Amy V. Harper, O.D.
Harper Eye Care
P.O. Box 306 - Kernersville, NC 27285-0306
Tel: (336) 993-3930 Fax: (336) 993-3979

TERM: This Authorization will remain in effect from the date of this Authorization until the Practice fulfills the request. By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization.

I understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization, the Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization of applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me.

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the Practice's Office Manager at the address listed above. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information.

Signature of Patient or Legally Authorized Representative

Date