HIPA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name _____ Date of Birth _____/_____/
LAST FIRST MI

Address _____ Social Security Number _____
STREET NAME

_____
CITY STATE ZIPCODE

I Authorize: _____
Name of designated individual, organization, or Provider

_____
Address

To release my health care information to **Los Gatos Eye Care, 15563 Union Ave., Los Gatos, CA, 95032** for the purpose of reviewing my records.

Information to be Released:

All medical records	All Dates
Rx only	Specific Dates:
Report only	

1. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.

2. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.

3. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

4. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

5. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment)_

_____ _____
Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient