HOFFNER
EYE CARE

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name_____ DOB_____

Address_____

Phone Number_____

I authorize _____

_____

to obtain/release my health information from/to:

_____

_____

Information to be released: ___ Copy of complete records

___ Copy of spectacle Rx

___ Copy of contact lens Rx

___ Other

Comments:

It is completely your decision 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 only exception to your right to revoke is if we have already acted in reliance upon this 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 person at the top of this form.

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.

Patient Signature:_____ Date:_____

Parent's Signature: _____ Date: _____