AUTHORIZATION FOR RECORDS RELEASE REQUEST

Doctor Name: _____

Clinic Name: _____

Address: _____ City/Zip: _____

Phone: _____ Fax: _____

Your patient listed below is requesting that their records be forwarded to Vision Care Center for review and further continuity of quality care. Thank you in advance for your prompt attention to this request.

Patient Name: _____ Date of Birth: _____

Last 4-Digits of Social Security Number: _____

1) Description of the information to be released:

_____ All information contained in the patient's file, including copies of medical records and copies of records received from any other person or firm with respect to the exam, treatment and care.

_____ Other: _____

2) Purpose of the release: _____

3) Date of Request: _____

April 2003, a new law took affect that created a nationwide standard for protecting personal health information. That law is commonly known as HIPAA. The HIPAA privacy regulations apply to everyone with access to personal medical information.

I understand that the information used or disclosed may no longer be protected under HIPAA. At Vision Care Center, we are committed to treating and using protected health information about you responsibly. We respect our legal obligation to keep health information that identifies you confidential and will follow the HIPAA regulations regarding this new requested information.

I have read and understand this form. I authorize the disclosure of my health information as described in this form. This authorization is valid for 90 days unless revoked in writing. I also have the right to revoke my authorization at any time and upon written request.

Signature: _____ Date: _____
Patient / Guardian / Legal Representative

Relationship to Patient: _____

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