Herkert Family Eye Care
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Indianapolis, IN 46227
(317) 784-5665
(317) 784-7011 Fax
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Authorization for Release of Identifying Health Information

Patient Name _____ Date of Birth_____

Patient Address_____

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

1. Description of the information to be released:

2. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual).

3. This form expires one year after I sign it or sooner if specified here _____

Please release my records **from**:

Office_____ Phone ( ) _____ Fax ( ) _____

Address_____

Please release my records **to**:

Office_____ Phone ( ) _____ Fax ( ) _____

Address_____

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 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 or electronic note telling us that your authorization is revoked.

When your health information is disclosed, as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

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.

Dated_____ Patient Signature_____

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_____