CURTIS OPTOMETRY GROUP

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____

Patient Address_____

Patient Phone Number_____

I authorize the professional office of my optometrist named above 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. Detailed description of the information to be release:
2. To whom may the information be released (name(s) or class(es) of recipients):
3. 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):
4. Expiration date _____ or event relating to the individual or purpose for the release: _____

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 the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed on the top of this form.

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.

Date _____ Patient _____

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 _____

Curtis Optometry Group

Statement to permit payment of insurance benefits to provider

I request that payment of authorized insurance benefits be made on my behalf to Curtis Optometry Group. I authorize any holder of medical or other information about me to release to the fiscal agent any information needed to determine these benefits payable for related services. I understand that if there is a deductible that has to be met, I will be responsible for these charges, in addition to the co-pay stipulated by my insurance.

I understand I will be responsible for paying for services rendered if my insurance company does not pay.

Recipient's Signature: _____

Date: _____

Acknowledgment of Receipt

I acknowledge being offered a copy of Curtis Optometry Group's Notice of Privacy Practices. This choice of taking a copy with me or not is entirely mine.

Date: _____

Patients Name: _____

Signature: _____