COLUMBUS VISION THERAPY

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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. **Information that may be released**: Name, SSN, ID number, RX information, diagnosis, ect
2. **Where we might release your info**: Health Insurance Company, labs that provide your glasses or contacts, pharmacies to fill or refill a prescription, a physician's office.
3. Information may be released at the request of the individual.
4. You may set an expiration date for this release: _____

It is completely your decision whether or not to sign this authorization form. Columbus Vision Therapy cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it at any time. Please send a notification in writing to the office administrator at the above information to cancel this authorization. An exception may occur if we acted in reliance upon an active authorization. When your health information is disclosed as provided in this authorization, the recipient may have no legal duty to protects its confidentiality; in some cases, the recipient may re-disclose the information. Sometimes, state or federal law changes this possibility. At Columbus Vision Therapy, we will never disclose your information to someone not bound by HIPAA confidentiality without your request or approval.

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 _____

Columbus Vision Therapy

Statement to permit payment of insurance benefits to provider

I request that payment of authorized insurance benefits be made on my behalf to Columbus Vision Therapy. 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 Columbus Vision Therapy's Notice of Privacy Practices. This choice of taking a copy with me or not is entirely mine.

Date: _____

Patients Name: _____

Signature: _____

TURN OVER