

Authorization to release Medical Information
HIPPA Compliant

The execution of this form does not authorize the release of information other than that specifically described below.

To: _____ Date: _____

Fax _____

I hereby authorize the release and communication of information both written and verbal between this office (below) and the party named above in all matters concerning the history and any examination, treatment and care in the case of:

(Print full name)

(Date of birth)

Please fax or mail any information relating to acuity, vision, visual skills, neurological and visual fields to:

Rebecca E. Hutchins, O.D., F.C.O.V.D.
7916 Niwot Road Box A
Niwot, CO 80503
303-652-0505
Fax: 303-652-0606

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient, but in any event **will expire 1 year from the date signed** or on this date supplied by the patient _____ or _____ days after signing date.

A copy of this Authorization may be used with the same effectiveness as an original.

HIPAA Required Statements:

I understand that non-research treatment may not be conditioned upon signing this release.

I understand that the information provided under this release may be subject to redisclosure by the recipient under circumstances no longer protected by HIPAA privacy rules.

I understand that I may revoke this release at any time, Except to the extent that action has already been taken to comply with it. To revoke this authorization, I must provide written notice to the health plan, doctor or health care provider named in this release and written notice to the organization or entity to whom I have authorized the release of information.

Patient Signature: _____ Date _____

Person authorized to sign for patient: _____ Date _____

Relationship to Patient: _____