THE Vision Care CENTER
421 Chestnut Street • Evansville, Indiana 47713

Authorization To Disclose Health Information

Patient Name: _____ DOB: _____ Medical Record#: _____

Current Mailing Address: _____

I authorize the use or disclosure of the above named individual's health information as described below.

- The following individual or organization is authorized to make the disclosure. _____

_____

- **Purpose or need for disclosure: (check one)**
  - ❑ Transferring to another facility/doctor
  - ❑ Continuing medical care (referral)
  - ❑ Insurance company only
  - ❑ Disability
  - ❑ Personal
  - ❑ Legal
  - ❑ Other _____

Do you have The Vision Care Center appointments that need to be cancelled?

❑ **No** ❑ **Yes If yes, which physician(s)**

_____

_____

- **Extent or nature of information to be disclosed: (check all that apply)**
  - ❑ Mental health ❑ HIV/AIDS status ❑ Communicable diseases ❑ Drug/Alcohol
  - ❑ Other _____

_____

_____

  - ❑ All Doctors ❑ Specific Doctor(s) _____

- **The above information may be disclosed to the following:** _____

_____

(name and address)

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department of The Vision Care Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire in 60 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed, for a reasonable fee, as provided in the Code of Federal Regulations 164.524 and pursuant to The Vision Care Center policy.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact The Vision Care Center's Privacy Officer, in writing, at 421 Chestnut Street, Evansville, IN 47713.

_____ _____

Signature of Patient or Legal Representative/Guardian Date

_____ _____

If signed by Legal Representative, relationship to patient Signature of Witness

In the case of x-ray films, it is understood that these films are the property of The Vision Care Center. After review, the films must be returned promptly to the Vision Care Center Radiology Department.

This form must be completed in its entirety before any information will be released.

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