EYE CLINIC OF GREAT FALLS, P.C.

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AUTHORIZATION FOR RELEASE OF /OR RECEIPT OF HEALTH INFORMATION

Patient Name ______________________________ Health ID #______________.
Patient Date of Birth __________________________

I authorize the professional office of my optometrist named above to:
Receive information from:

____

Release information to:

____

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ❑ Medication list
- ❑ History and physical
- ❑ Laboratory tests results from (date) ___________ to (date)_____________
- ❑ Consultation reports from (doctors' names)______________________
- ❑ Entire health record____
- ❑ Other____

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I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
This information may be disclosed to and/or released by the following individuals or organization:
Eye Clinic of Great Falls, P.C. and /or Dr P.J.Stibel, Dr A.E.Thompson, Dr D.M.Hager or Dr. J.A.Hager
Address: 509 2nd Ave. North, Great Falls, MT 59401 Fax: (406) 452-2015 for the purposes of providing eye cares services.
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 health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:__________________________. If I fail to specify an expiration date, event, or condition, this authorization will expire in (six months, one year, as applicable to your state law or facility guidelines).
I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I may inspect the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. Questions regarding disclosure may be directed to Ms. Judy Twedt, privacy officer at the Eye Clinic of Great Falls, P.C.

________________________________ ________________________
Signature of Patient or Legal Representative Date

________________________________ ________________________
If signed by Legal Representative, Relationship To Patient Signature of Witness