



Brain & Eye Connection Vision Clinic, PC

A Vision Clinic with more than just your Eyes in Mind

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ Birthday: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip Code: _____

I, _____, authorize Brain & Eye Connection Vision Clinic, PC to:

Check One of the following:

Disclose my protected health information to:

- School Teacher(s)
- School Nurse/Counselor
- School Principle
- Primary Care Optometrist
- Primary Care Doctor/Pediatrician
- Occupational Therapist
- Physical Therapist
- Psychologist/Psychiatrist/Counselor

Request copies of my health information from:

Name

Mailing Address

City State Zip

Specifically covering treatment from (specify dates or event): _____ to _____

Purpose of use and/or disclosure of protected health information: _____

Specify type of information to be used and/or disclosed:

- Complete Record
- Last Comprehensive Exam
- Eyeglasses prescription
- Contact Lens prescription
- Vision Report Letter for Educators
- Developmental Vision Exam Report
- Vision Therapy records / Progress notes
- Other (specify): _____

This authorization is valid for 12 months after date signed unless specified here: _____

Rights

I understand that I do not have to sign this Authorization and treatment is not conditioned on obtaining this authorization.

I have a right to receive a copy of this Authorization.

I have a right to revoke this authorization at any time by submitting a signed written request. The only exception to this right is if the authorized party has already acted in reliance upon this authorization.

I understand that if the person(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by the Privacy Rule in the Code of Federal Regulations.

I understand that a fee may be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing to anyone other than another health care provider.

Signature of Patient or Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

Carolanne H. Roach, OD 1530 SW 89th St, Bldg D-2, OKC, OK 73159 (405) 703-3163

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