

Chapel Hill EyeCare Optometry PA
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Chapel Hill, NC 27515-3420
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Carl Stice

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient name: _____ Patient number: _____

Patient address: _____

Patient phone number: _____ Patient's Date of Birth: _____

I authorize the professional office of my optometrist named above to release identifying health information relating to me under the following terms and conditions:

Specific description of the information to be released including the dates of service: _____

2. Name(s) or class or persons to whom the information may be released: _____

3. The purpose(s) for the release of health information:

() At the request of the individual

() Other: _____

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

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.

Patient signature: _____ Date: _____

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: _____