**Authorization For Treatment And Release Of Information**

Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Many of our patients allow family members and/or friends to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient’s consent. If you wish to have your medical or billing information released to family and/or friends you must sign this form. Signing this form will only give information to person(s) indicated below. I hereby authorize Blink Vision Center to release my medical and/or billing information to the following individuals:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By authorizing the above person(s) to obtain medical/billing information, I understand that the following information can and may be released:

* Results of vision exam, including prescriptions and suggested treatment
* Financial information
* Diagnostic tests and findings (e.g. retinal imaging, visual field testing, VEP, ERG)
* Medical history
* Any information necessary for treatment

**Patient Rights:**

* I have the right to revoke this authorization at any time, and I have the right to obtain the protected health information to be disclosed as described in this document by sending a written notification to Blink Vision Center.
* A revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
* Information used or disclosed, as a result of this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law
* This authorization shall be enforced and effective until revoked by myself, the patient, signing the authorization.

 Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_