110 N. Adelaide
Terrell, TX 75160
(972)563-3253
(formerly Family Vision Center)

1830 S. Buckner Blvd.
Dallas, TX 75217
(214)398-1144
(formerly Grove Eye Clinic)

Authorization for Treatment and Release of Information

Full Name:_____ DOB: _____
(Please Print)

Many of our patients allow family members and/or friends to call and request medical or billing information. Under the requirements of the Health Insurance Portability and Accountability Act (HIPAA) we are not allowed to give this information to anyone without the patient/guardian's consent. If you wish to release your medical and/or billing information and/or have your glasses/contact lenses dispensed to someone other than the patient/guardian (including mother, father, spouse/partner, former spouse/partner, children, sister, brother, grandmother, grandfather, aunt, uncle, friend, etc), you must add their names below and sign this form.

I hereby authorize Blink Vision Center to release my medical and/or billing information and/or glasses/contacts to the following individuals (please print):

_____ Relationship to Patient: _____
_____ Relationship to Patient: _____
_____ Relationship to Patient: _____
_____ Relationship to Patient: _____
_____ Relationship to Patient: _____

By authorizing the above person(s) to obtain medical and/or billing information and/or pick up your glasses/contacts, 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 (i.e. retinal imaging, visual field testing, VEP, ERG)
* Medical history
* Any information necessary for treatment
* Glasses and/or contact lenses

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/guardian) signing this authorization.

Patient/GuardianSignature:_____Date:_____