

Ridgefield Vision Center
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Richmond, VA 23233
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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____
Patient Date of Birth: _____
Patient Address: _____
Patient Phone Number: _____

I authorize the professional office of my optometrist named above to release health information identifying me (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Description of the information to be released:
2. To whom may the information be released:
3. The purpose(s) for the release:
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.

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 and 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.

Dated: _____ Patient Signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and source of authority to sign this form:

Relationship to patient: _____
Print Name: _____
Source of Authority: _____