Montenare Eye Care & Vision Therapy
Dr. Michael Montenare – Doctor of Optometry

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFO

Patient Name _____ DOB _____

Address _____

Telephone # _____

The Notice of Privacy Practices describes the uses and disclosures of patient health information that may be made without your authorization or consent. This authorization may be used for those specific uses and disclosures of information that require further authorization from you. 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. Detailed description of the information to be released:
   - ☐ All medical records (no restriction)
   - ☐ Describe information _____
2. To whom the information may be released (name(s) or class(es) of recipients):
   - ☐ All (no restriction)
   - ☐ Recipients (List) _____
3. The purpose(s) for the release:
   - ☐ At request of patient
   - ☐ Other (describe) _____

It is completely your decision whether or not to sign this authorization form. 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 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.

Signature _____ Date _____

If you are signing as a personal representative of the patient, please print your name and describe your relationship to the patient:

Print Name _____ Relationship to Patient _____

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