AUTHORIZATION FOR RECORDS RELEASE

Patient Name _____

Date of Birth _____

Patient Phone Number _____

I hereby authorize the release of my health/vision information ***FROM***:

_____

_____

_____

_____

1. Description of the information to be released:

   _____ All information contained in the patient's file, including copies of medical records and copies of records with respect to the exam, treatment, and care.

   _____ Other: _____

2. I hereby authorize the release of my health/vision information ***TO***:

   _____

   _____

   _____

   _____

3. Date of request: _____

The HIPPAA privacy regulations apply to everyone with access to personal medical information. A New Concept Optical, is committed to treating and using protected health information about you responsibly. We respect our legal obligation to keep health information that identifies you confident.

I have read and understand this form. I authorize the disclosure of my health information as described in this form. This authorization is valid for 90 days unless revoked in writing. I also have the right to revoke my authorization at any time and upon written notification.

Signature: _____ Date: _____

(Patient / Guardian / Legal Representative)

Relationship to patient: _____