826 Harrison Avenue
Panama City, Florida 32401
Office 850-769-1404 – Fax 850-769-0748

AUTHORIZATION OF RELEASE OF IDENTIFYING HEALTH INFORMATION:

Patient Name: _____ Parent/Guardian (if minor): _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ DOB: _____ Phone: _____

I authorize my doctor's office to release health information under the following terms and conditions:

1. Information to be released: _____ Glasses Prescription _____ Contact Lens Prescription
   _____ Complete Medical Records _____ Other
2. Release of Information FROM:
   _____ Academy of Eyecare _____ Other: Name: _____
   Phone: _____ Fax: _____
   Address: _____
3. Release of Information TO:
   _____ Academy of Eyecare _____ Other: Name: _____
   Phone: _____ Fax: _____
   Address: _____
4. The purpose(s) for the release:
   _____ Personal, at the request of the individual _____ Continuity of Care
   _____ Legal Purposes or Disability Determination _____ Insurance Claim or Application

Academy of eyecare is required to keep your personal health information confidential. If you authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. I understand that the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment HIV/AIDS, and genetics.

The authorization may be revoked at any time when revocation is made in writing to the provider/facility releasing the information. I may be charged for copies in accordance with state law. The provider/facility will not condition treatment on whether I sign the authorization. This authorization expires one year from the date of signing unless I indicate an earlier date here: _____.

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.

Patient (or Guardian) Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Witness Signature: _____ Printed Name: _____

For Office Use Only:

Date Completed: _____ Initials: _____

_____ Mailed _____ Faxed _____ Given to Patient