A family tradition of exceptional vision care

Clarke EyeCare Center

Authorization to Disclose/Release Health Information

Patient: _____ Account #: _____ DOB: _____

Please Note: Copy Fee May Be Charged for Medical Records

Obtain From: _____ Release To: _____

Clarke EyeCare Center
4314 Kemp Boulevard
Wichita Falls, Texas 76308

Name: _____

Address:_____

City, ST, Zip: _____

Phone:_____ Fax:_____

Data Requested: (check all that apply)

☐**Exam Complete** ☐**Contact Lens Prescription** ☐ **Glasses Prescription**

☐**Fundus Photo/Visual Field/Ocular Coherence Tomography** ☐**Other: _____**

☐**Dates of Service Requested From: _____**

Purpose of Disclosure:

☐**Continuation of Care** ☐**Legal Purposes** ☐**Insurance** ☐**Personal Use**

☐**Other (specify): _____**

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management or privacy officer. I understand this revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or privacy officer by calling 940-691-5645.
Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

_____ _____

Signature of Patient/Parent/or Legally Authorized Representative (LAR) **Date**

_____ _____

If Signed by LAR, Authority to sign (Guardian, Parent, Etc.) **Date**