NeuroSight Vision Care
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HIPAA

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient's Name:_____

In some cases, such as follows, HIPAA does NOT require a signed patient release:

- Seeking assistance from consultants
- Making referrals of patients for care
- Writing, sending or filling prescriptions
- Office management including submitting and posting claims
- Disclosures as required by local, state and federal law

I authorize this office to release health information about me (including, ONLY IF APLLICABLE, information about HIV, AIDS, substance abuse and mental health).

Excluding above, I (the patient) want the following restrictions on information released:

1. Description of information to be released:_____
2. Information to be restricted:_____
3. Please list who we may share your health information with:_____
   _____
   _____
4. Expiration of the release:_____

It is your voluntary decision to sign or not sign this form. We will not refuse treatment if you do not sign. You may revoke (in writing), this authorization later for any future release. When your health information is disclosed by this form, the recipient may not have any legal duty to protect it and may re-disclose it.

I HAVE READ AND UNDERSTAND THIS FORM. I AM VOLUNTARILY SIGNING IT TO DISCLOSE MY HEALTH INFORMATION AS DESCRIBED.

Patient Signature:_____ Date:_____

If you are signing as a representative of the patient, please describe:

Your Name:_____
Your Relationship to the Patient:_____
Source of your Authority:_____