NeuroSight Vision Care
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HIPAA

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient's Name: _____

I authorize this office to release health information about me (including, *Only If Applicable*, information about HIV, AIDS, substance abuse and mental health).

I (the patient) want the following information released:

◇ Medical Records ◇ Billing ◇ Imaging ◇ Diagnostic Testing

Please list who we may share your health information with & what items you would *not* want shared:

_____

_____

Expiration of the release (no expiration if not listed): _____

It is your voluntary decision whether or not to sign this form. We will not refuse treatment if you do not sign. At any time, you may revoke, in writing, this authorization for any future release to those listed above. 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.

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

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

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: _____

*ONLY Sign below if you are **refusing** to sign the above acknowledgement.*

Signature *Name* *Date*