



AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____ Patient DOB _____

Patient phone number _____ Patient address _____

Records Released <input type="checkbox"/> FROM or <input type="checkbox"/> TO:	Records Released <input type="checkbox"/> FROM or <input type="checkbox"/> TO:
VisionHealth EyeCare PLLC	Name:
David J. Langford, O.D.	Address:
1550 N. Mains St • North Logan, UT 84341	City/State/Zip
T: 435-753-3906 F: 435-753-3918	Telephone #: Fax #:

I authorize the above named "From" to release to "To" health information identifying me under the following terms and conditions:

The purpose of this disclosure is: _____

Dates of service: All From ___/___/___ to ___/___/___ Release the following information: All information or:

<ul style="list-style-type: none"> • Discharge Summary • History & Physical • Consultation(s) • Operative Report(s) • Progress Notes 	<ul style="list-style-type: none"> • Pathology Report(s) • Radiology Report(s) • Lab Report(s) • Cardiology Report(s) • Psychiatric Record(s) 	<ul style="list-style-type: none"> • Treatment Plan(s) • Alcohol/Drug Treatment Record(s)* • Itemized Billing Statement • Emergency Record(s) • Other records as specified: _____
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*Alcohol/drug treatment records are protected by Federal Rule 42 CFR, Part 2.

I allow this Authorization to remain in effect for 180 days or: • From the date of this Authorization until: ___/___/___ • Until the following event occurs:

I understand that when my health information is disclosed as provided in this authorization, the recipient ("TO") often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility. I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR §164.524.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

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.

Dated _____ Patient signature _____
 If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:
 Relationship to Patient _____ Signature _____
 Source of Authority _____ Print Name _____