Authorization for Release of Identifying Health Information

Coos Bay Vision Center, Inc.
Kathy Jackson, Privacy Official

Patient Name: ____

Patient Address: ____

Patient Phone Number (_____) _____ _________

I authorize Coos Bay Vision Center, Inc. to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, genetic information, and HIV infection or AIDS) under the following conditions:

Specific info to be released: ____

Reason for the release: ____

Name & address of recipient: ____

Termination date for authorization: ___ / ___ / ______

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the Notice of Privacy Practices.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Signature: ___________________________________

Date: ___ / ___ / ______

If you are signing as a personal representative of the patient, please indicate your relationship

Representative: _______________________________________

Relationship to Patient: _________________________________