AUTHORIZATION FOR RELEASE OF
IDENTIFYING HEALTH INFORMATION

All About Eyecare, PC
15101 E. Iliff Ave., Suite100
Aurora, CO 80014
303.366.1235
Jackie Toelle-Sprague, Privacy Official

Patient Name ____

Patient Address ____

Patient Phone Number ____

I authorize All About Eyecare, PC to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions:

1. Detailed description of the information to be released:

    1. To whom may th4e information be released:

    1. The purpose(s) for the release(if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual

    1. Expiration date or event relating to the individual or purpose for the release:

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 Date

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

____________________________________ ___________________________
Representative Relationship to Patient