Monroe Vision Clinic, Inc.

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ **Birth Date:** _____
(Last) (First) (Middle)

Address: _____ **Phone #:** _____
(Street address)

_____
(City) (State) (Zip Code)

Other names your records may be listed under:_____

I hereby authorize information to be released by Monroe Vision Clinic or

_____
(Provider Name) (Facility Name)

_____ Phone #: _____
(Street address)

_____
(City) (State) (Zip Code)

I hereby authorize information to be released to Monroe Vision Clinic or

_____
(Provider Name) (Facility Name)

_____ Phone #: _____
(Street address)

_____
(City) (State) (Zip Code)

Information requested:

□ All records
□ Last 3 years
□ For the date(s) of service from: _____ to _____

I authorize the release of my complete health record with the exception of the following information:

□ Mental Health Records □ Communicable Disease (including HIV and AIDS)

□ Alcohol/Drug Abuse Treatment □ Other (please specify):_____

Purpose: I understand this medical information may be used for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

Expiration: Unless revoked earlier this authorization will expire 90 days after the date it is signed.

Right to Revoke: I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective if information is needed to process payment for healthcare that has already been provided or other substantial action has been taken in reliance on the authorization.

X _____ _____
(Signature of patient, parent, or personal representative) **Date:**

I hereby declare that I am the natural or adoptive parent or legal guardian of said child and there is no legal document restricting or prohibiting my access to such medical records.

X _____
(Printed Name of parent, or personal representative) (His or her relationship to patient)