Family Eye Care Center, P.C.
5118 W 26th Street, Sioux Falls, SD 57106

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _________________________ D.O.B. ______________ Phone : ____________________

Patient Address: ________________________City _________________ State ________ Zip __________

1. I authorize the use of disclosure of the above named individual's health information as described below.

2. _______________________________ Is authorized to make the disclosure.

3. The information to be used/disclosed is as follows:

   - Records from all Routine Eye Exams
   - Records from all non-routine eye exams
   - Medical history information
   - Medications prescribed
   - Consultation reports and letters of referral to or from other doctors
   - All of the above

4. I understand that the information in my health record may include information relating to sexual transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse.

5. This information may be disclosed to and used by the following individual or organization;

   Organization / Individual's Name: ____

   Organization / Individual's Address: ____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

____ ___________________________

Signature of Patient or Legal Representative Date

____ ___________________________

If signed by Legal Representative, Relationship to Patient Signature of Witness