THIS AUTHORIZATION MUST BE RETURNED WITH A SIGNED COPY OF THE <u>PATIENT'S PICTURE ID</u>

AUTHORIZATION FOR RELEASE OF INFORMATION

<u>Section A: Must be completed for all authorizations</u>

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:____ **ID Number:**________________________

Persons/Organizations providing the information:
Art Optical Contact Lens, Inc.
3175 Three Mile Rd NW
Walker, MI 49544

Persons/Organizations receiving the info:
____
____
____

Specific description of information (including date(s)): ____
____
____

Name & Address (must include State) of Eye Care Practitioner where contact lens RX originated:____________
____

<u>Section B: Must be completed only if a health plan or a health care provider has requested authorization</u>

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure?: ____
   ____
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_____ No___

2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials:__________
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials:_______

<u>Section C: Must be completed for all authorizations</u>

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _ _/_ _/_ _ _ _(DD/MM/YY) Initials:____________
   or after all issues related to this event have been resolved.

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials:____________

____ ____________________

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

Printed name of patient's representative:____

Relationship to the patient:____

****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****

You may not use this form to release information for treatment or payment exceptwhen the information to be released is psychotherapy notes or certain research information.