AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

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:_____ **DOB:**_____

Persons/Organizations providing the information:

Art Optical Contact Lens, Inc.
3175 Three Mile Rd NW
Walker, MI 49534
PH# 800-253-9364/ **Fax# 800-648-2272**

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:_____

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

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:_____

Section C: Must be completed for all authorizations

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. If this field is left blank, authorization will expire 2 years from the date it is signed.

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