Professional VisionCare, Inc.

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937 Polaris Woods Blvd, Suite B, Westerville, OH 43082 • Tel 614-898-5285 • Fax 614-898-5310
Public Information Officer: Emily Trimmer • Privacy Officer: Raquel Miller
Security Officer: Anita Gardner • Review Officer: Carole R. Burns, O.D.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name:_____ Phone Number: _____

Address:_____ City:_____ State:____ Zip:_____

I authorize Professional VisionCare, Inc. to release health information identifying me under the following terms and conditions:

1. **Detailed description of the information to be released**:

_____

_____

2. **To whom may the information be released:**

_____

☐ **Fax: _____** ☐ **Mail to address above** ☐ **Electronic Transmission**

☐ **Other: _____**

3. **The purpose(s) for the release:**

_____

4. **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 cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the Public Information Officer listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. The recipient may re-disclose the information as he/she chooses, with exception to state or federal laws prohibiting such disclosures.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____Source of Authority _____