



# NORTHWEST OHIO VISION CENTER

## Authorization to Disclose/Release Health Information

Patient: \_\_\_\_\_ Account #: \_\_\_\_\_ DOB: \_\_\_\_\_

**Please Note: Copy Fee May Be Charged for Medical Records**

**Obtain From: \_\_\_\_\_ Release To: \_\_\_\_\_**

**Northwest Ohio Vision Center**

1313 West High

Bryan, OH 43506

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Data Requested: (check all that apply)

- Exam Complete
- Contact Lens Prescription
- Glasses Prescription
- Fundus Photo/Visual Field/Ocular Coherence Tomography/GDX
- Other: \_\_\_\_\_
- Dates of Service Requested From: \_\_\_\_\_

### Purpose of Disclosure: (check all that apply)

- Continuation of Care
- Legal Purposes
- Insurance
- Personal Use
- Other (specify): \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management or privacy officer. I understand this 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 consent a claim under my policy. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from date signed.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or privacy officer by calling 419-636-1531. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_.

\_\_\_\_\_  
**Date:** \_\_\_\_\_

**Signature of Patient/Parent/or Legally Authorized Representative (LAR)**

\_\_\_\_\_  
**Date:** \_\_\_\_\_

**If signed by LAR, authority to sign (Guardian, Parent, Power of Attorney, etc.)**