Lifetime Eyecare Associates
2428 Reidville Rd
Spartanburg, SC 29301
864-576-7225 864-576-7226 (fax)

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient _____

Address _____

Phone Number _____ **Date of Birth** _____

Release from _____

_____

Phone _____ **Fax** _____

I authorize the professional office of _____to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

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 office contact person 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. In many cases the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

(For marketing authorization, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization)

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.

Date_____ **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 _____