HEMLER FAMILY EYE CARE

AUTHORIZATION FOR RELEASE OF HEALTH AND BILLING INFORMATION AND PRODUCTS

Patient Name_____ Date of Birth_____

Patient Address_____

Patient Phone Numbers (Home)_____(Work)_____(Cell)_____

I authorize the professional office of my optometrist, Edward Hemler, O.D./Katie Hertz, O.D./Selinda Van Dell, O.D. to release health and other information identifying me under the following terms and conditions:

1. To whom may your private medical information be released? Please name the people that you authorize to receive your private medical information:

   _____ _____

   _____ _____

2. What information can be released:
   - ☐ Contact lens prescription
   - ☐ Eyeglasses prescription
   - ☐ Results of diagnostic tests
   - ☐ Prescribed medication
   - ☐ Billing information
   - ☐ Other_____

3. Is there a particular person(s) who should NOT get this information?_____

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. Please understand that we will NOT dispense any materials or information to anyone, but you, if this authorization is not signed.

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, please provide us with a written note telling us that your authorization is revoked.

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.

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

I ACKNOWLEDGE THAT I HAVE READ (OR BEEN OFFERED) A COPY OF DR. HEMLER'S / DR. HERTZ'S / DR. VAN DELL'S/ DR. FURMAN'S NOTICE OF PRIVACY PRACTICES.

Patient Signature_____ Date_____

If you are signing as a personal representative of the patient, describe your relationship to the patient:

Relationship: (circle one) Mother Father Legal Guardian Other:_____

Print Name:_____