Authorization for Release of Information

I hereby request the disclosure of information from my record.

Patient Name: _____
Address: _____
City/State/Zip:_____/_____/_____
Phone: (_____)_____ DOB: _____/_____/_____

The information is to be released **TO/FROM**:

Name/Agency: _____
Address: _____
City/State/Zip:_____/_____/_____
Phone: (_____)_____
Fax: (_____)_____
E-mail: _____
Contact Person(s): _____

The information is to be released by mail, phone, email, or fax **TO/FROM**:

Advanced Family Eyecare
14000 Quailbrook Dr.
Oklahoma City, OK 73134
(405) 751-7727/ fax (405) 755-1875

The information to be released is as follows:

❑ Any information contained in the patient's record

❑ Only information related to the patient's educational success (Specify)

_____
_____
_____

- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date authorized.
- I understand that the recipient of the disclosed protected health information may not have any legal obligation to maintain the further confidentiality of the protected health information.
- We cannot refuse to treat you if you choose not to sign this form.

Signature: _____ Date: _____
(Patient, Parent, or Legal Guardian)