ARMSTRONG & OPTOMETRY ASSOCIATES

Authorization for Release of Patient Information

Patient's Name: _____ DOB:_____

Address:_____

I hereby authorize the release of information as listed below:

From: _____ **To:**_____

_____ _____

_____ _____

I authorize the release of my health information identifying me in including when applicable information on substance abuse, AIDS, or HIV infection and mental health information. I understand that I can revoke this authorization, in writing at any time by sending written notification. I understand that I have the right to inspect or copy health information used or disclosed as allowed by federal law. I understand that information used or disclosed pursuant to this authorization could be subject to disclosure by the recipient. I understand only 5 years of records will be copied. It is my decision to sign this authorization.

Purpose of request: _____

_____ _____

Signature of patient or responsible party Date

A parental signature is required for minors (under age 18). When a patient is deceased, physically or mentally impaired the appropriate representative of the patient must sign this authorization.

_____ _____

Staff Witness Date

2020 S. State Road 135, Suite 300
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