AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Johnson Eyecare PC
1525 31st Ave SW, Suite E
Minot ND 58701
(701) 857-6050
Telli Johnson, Privacy Official

Patient Name _____ DOB:_____

Patient Address _____

Patient Phone Number _____

I authorize to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions:

Information to be released_____

Record requested from:
Name & Address _____
_____
_____

Record released to:
Name & Address _____
_____
_____

☐ I acknowledge Johnson Eyecare PC does NOT utilize secure email and requesting to have my records released to me through their email system could pose a risk to my security and privacy. I will not hold Johnson Eyecare PC responsible for any security breach of my private health record transported in this manner.

Purpose of the release_____
Expiration date for the release (if applicable)_____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices*.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship.

_____ _____
Representative Relationship to Patient