AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION
(HIPAA Form)

Patient Name: ____ Date of Birth:______/______/___________

I authorize Pursuit Vision Center to release health information identifying me including diagnosis, records, examination rendered to me, and claims information under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released:
   [ ] Spouse____
   [ ] Child(ren)____
   [ ] Other____

Messages:
Please call [ ] my home [ ] my work [ ] my cell number_______________________________

If unable to reach me [ ] you may leave a detailed message
[ ] please leave a message asking me to return your call

The best time to reach me is (day)_______________________ between (time)__________________

The Release of Information will remain in effect until terminated by me in writing.

I acknowledge that I have received or had the opportunity to review a copy of Pursuit Vision Center's Notice of Privacy Practices Policy has been explained to me in brief.

Signed: ____ Date ___/___/_______

If you are signing as a personal representative of the patient, please list relationship below:

Relationship to Patient______________________________ Print Name_____________________________

Emergency Contact Form:

In case of an emergency in our office, please list who we should contact.

Patient Name: ______________________________________ DOB: _______________________________

Contact: ____ Phone: _______________________________

Relationship: ____