AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Vision Source Albany
2809 Old Dawson Road
Albany, GA 31707
229.888.3937
Cynthia Mann, Privacy Official

Patient Name ____

Patient Address ____

Patient Phone Number ____

I authorize Vision Source Albany 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:____

Information Released To:____

Reason Information is released: Patient Records/ Other: ____________________________
Compensation Charge for Information Release: YES/NO

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

This release expires 90 days after the signature date.