Records Release Authorization

Name______________________________________DOB______/______/ ______ Date_____/______/ ______

I authorize Northern Vision Eye Care (NVEC), its physician(s) and medical records personnel to disclose and/ or request the protected health information described below to:

☐ Request records to: ☐ Request records from:

Eye Doctor ____

City/State ____.

Please include: ☐ All records on file ☐ Billing Information

This authorization covers all past, present and future periods.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until__________(date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my author-i zation was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Humane Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse.

Signature of patient____Date _______________
or legal representative/relative

Signature of witness____Date _______________

PLEASE NOTE:
It may take up to 30 days to release information.

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.

Northern Vision Eye Care delivers state of the art medical, surgical and optical care with a passion for excellence, individuality and community service.