Drs. Roush and Will Optometrists, Inc.
AUTHORIZATION FOR RELEASE/DISCLOSURE OF
PATIENT'S HEALTH INFORMATION

Name:
Date of Birth:
Account #:

I authorize Drs. Roush and Will Optometrists, Inc. to disclose/release information from the health records of the above-named patient for the time period of:
☐ 1st visit through 12-31-2099
☐ 1st visit up to 18th Birthday _________ (fill in date of 18th birthday)

The reason for this release is: ☐ My/Patient request ☐ Other Request (whom) ___________________________

I request that: ☐ Medical ☐ Financial ☐ Both medical and financial information may be released

These copies or information may be released/disclosed to the following persons and/or organizations:

NAME	RELATIONSHIP	PHONE #	CITY

There is no need to list your physicians and/or insurance company.

I, the undersigned, understand that treatment, payment, enrollment, or eligibility benefits may not be conditioned on my signing this authorization and that I may refuse to sign this authorization. I understand that I may *REVOKE* this authorization at any time in writing, *EXCEPT* to the extent that action has been completed. See the Notice of Privacy Practices for specific instructions on revocation. The authorization shall remain valid until revoked, upon the expiration of the above date, or after sixty (60) days if no date is written, whichever comes first. I understand that I am giving permission to use/disclose protected health information which may include, if so designated by me, treatment for physical and/or emotional illness, communicable diseases, alcohol and drug abuse treatment, and/or HIV, AIDS or AIDS-related information. I understand that the information released may be subject to re-release by the recipient and may no longer be protected by any privacy rules or regulations. I acknowledge that I have read and understand the above and agree that this authorization was completed prior to my signature. I further agree that a copy of this authorization, whether a photocopy, carbon copy, or otherwise shall have equal standing as if it were an original and can be relied upon by Drs. Roush and Will Optometrists, Inc.

___________________________________ ________________
Patient Signature (as required by law) Date

Patient is unable to give authorization because patient is: a minor ________ year(s) of age; or is disabled
(Describe disability): ____

The undersigned hereby certifies and attests that he or she is the duly authorized representative of the patient and has lawful authority to enter into this authorization on behalf of the patient.

___________________________ ________________________________ _____________
Signature of Legal Representative Printed name of Legal Representative Date