AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Vision Source - Richmond
5610 W. Grand Parkway South, Suite 500
Richmond, Texas 77406
281-232-2024
281-232-2013 FAX
visionsourcerichmond@gmail.com

Patient Name _____

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) to Vision Source Richmond under the following conditions:

The Following list of people or office may have access to **any Personal Healthcare Information (PHI),** *at the patient's request*, in order to inform and involve these individuals in the healthcare of the patient. This has no expiration date but may be revoked by the patient at any time by submitting a formal request in writing to our Privacy Officer.

VISION SOURCE – RICHMOND ---- PLEASE FAX ALL RECORDS INCLUDING IMAGES

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