AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Advanced Eye Care
2700 Paramount Blvd
Amarillo, TX 79109
Lacrecia Garza, Privacy Official
(P) 806-355-9536 (F) 806-353-5572

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

I authorize Advanced Eye Care to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV or AIDS) under the following conditions:

Individual / Healthcare Provider / 3rd Party: _____

Address: _____

Fax Number: _____

Phone Number (optional): _____

Reason: _____

It is 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*.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Signature of Patient or Legal Representative Date