REQUEST FOR RELEASE OF HEALTH INFORMATION

Joseph Torres. O.D.
Eye Carumba Optometry
Four Embarcadero Center
Lobby Level
San Francisco, CA 94111

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

(NOTE: This form cannot be used to authorize a release of HIV-related information.)

Patient Name: ____
Last First M.I.

Patient Address: ____
No & Street City State Zip

Date of Birth: ______________________ Home Phone: (______)______________________

INFORMATION TO BE DISCLOSED:

☐ Record of last exam ☐ Spectacle Prescription ☐ Contact Lens Prescription

RECIPIENT: Name of person or class of persons to whom the Practice may disclose my health information:

Joseph Torres. O.D.
Eye Carumba Optometry

Address to which my health information should be delivered:

Four Embarcadero Center, Lobby Level, San Francisco, CA 94111
Tel: (415) 772-8282 Fax: (415) 772-8222

TERM: This Authorization will remain in effect from the date of this Authorization until the Practice fulfills the request.

By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s) ("At the request of the patient" is sufficient if the patient is initiating this Authorization):

At the request of the patient.

I understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization , the Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization of applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me; except, however, if my treatment at the Practice is for the sole purpose of creating PHI for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization. **If my treatment is related to my participation in a research study, I understand that the Practice may refuse to treat me if I do not sign this Authorization.**

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the Pratice's Office Manager at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask question s about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

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Signature of Patient or Legally Authorized Representative Date