Adirondack Eye Care Center
151 Main Street Suite 1
Boonville, NY 13309
315-942-2122

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____

Patient Address: _____

I authorize the professional office of my doctor, to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. **Detailed description of the information to be released:**

   ☐ **Billing and Medical Purposes only**

   ☐ **Name of other party to be given access to your information**

_____

2. In order to bill your insurance or share medical information for any referrals that we may make on your behalf we need your written permission, by signing below you are giving us that authority. Without this signature we can not bill your insurance for you and you would be responsible for all fees accrued during this visit

3. Expiration date or event relating to the individual or purpose for the release:
It is completely your decision whether or not to sign this authorization form. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.
When your health information is disclosed, as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes state or federal law changes this possibility.
If you are authorizing us to use your health information for marketing activities, please be advised that we may receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.
I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature _____ **Date** _____
If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:
Relationship to Patient _____

Print Name _____

Source of Authority _____