AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Optical Expressions
12422 Olive Blvd.
Creve Coeur, MO 63141
314.579.0909

Optical Expressions
7718 Forsyth
Clayton, MO 63105
314.721.0909

Judie Miles, OD, Privacy Official

Patient Name ____

Patient Address ____

Patient Phone # ____

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

1. **Detailed description of the information to be released:**____
2. **To whom the information will be released:**

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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 us 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. We will not receive a financial benefit from disclosing this health information about you.

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