Corporate Office
217 Clarkson Rd Ellisville, MO 63011 636-227-2600 fax 636-200-4020

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize Clarkson Eyecare to

release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Fax Number_____ Email Address_____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

I understand that if my medical records contain information concerning HIV (AIDS) or drug or alcohol abuse, those portions of my record are protected by state or federal law. I hereby release and forever discharge CLARKSON EYECARE, its physicians, and employees from any liability arising out of the release of my medical records as specified above and pursuant to this signed authorization.

I understand that I have a right to cancel this authorization at any time. I understand that authorizing release of this health information is voluntary. I can refuse to sign this authorization. I don't have to sign this form to receive treatment. I understand I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Clarkson Eyecare Corporate office at 636-227-2600.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.