



SACRAMENTO CONTACT LENSES & OPTOMETRY, INC.

SACRAMENTO

701 Howe Avenue, Suite G-48
Sacramento, California 95825
Fax (916) 921-5494
(916) 921-8080

ROSEVILLE

1700 Eureka Road, Suite 180
Roseville, California 95661
Fax (916) 789-1332
(916) 789-2020

Authorization for Release of Medical Information

I, _____ (patient), hereby authorize **Sacramento Contact lenses and Optometry, Inc** to release personal health information. This information will be provided to _____ (Doctor and/or Company), for the purpose of _____ (specific purpose for information is to be used).

The type of information that may be released and used by the Doctor and/or Company includes:

(Check where applicable and include dates as appropriate.)

- Most recent history or physical exam results
- Most recent history of contact lenses
- Certification of Serious Health Condition, as required for leave under federal or state law
- Medical information related to the disability of _____.
- Medication list
- List of Allergies
- Other (specify) _____

This authorization is valid from _____ (start date) to _____ (end date). If I fail to specify an expiration date, this authorization expires in 90 days after the date of my signature below unless previously revoked in writing, I understand that I have the right to revoke this authorization at any time by giving written notice to the Company or the provider/practitioner named above. Such revocation shall not apply to any information that has been released prior to revocation of the authorization.

I understand that authorizing the disclosure of my medical information is voluntary. I can refuse to sign this authorization. I further understand that I have the right to inspect and copy the information disclosed as a result of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, which may or may not be protected by federal or state confidentiality rules. If I have any questions about the disclosure of use of their information, I may contact Ginger Himelight, Privacy Manager or AJ Bennett, contact person.

Signature of Patient or Legal Representative of Patient

Date

If signed by Patient's Legal representative, describe your (legal representative's) authority to act: _____