



# SACRAMENTO CONTACT LENSES & OPTOMETRY, INC.

**SACRAMENTO**  
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## Authorization for Release of Medical Information

I, \_\_\_\_\_ (patient), hereby authorize \_\_\_\_\_ (Doctor and/or Company), to release personal health information. This information will be provided to **Sacramento Contact lenses and Optometry, Inc.** 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 Lorie Deering, Privacy Manager.

\_\_\_\_\_  
Signature of Patient or Legal Representative of Patient

\_\_\_\_\_  
Date

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