SACRAMENTO CONTACT LENSES & OPTOMETRY, INC.

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

ROSEVILLE
2150 Professional Drive, Suite 190
Roseville, California 95661
Fax (916) 789-1332
(916) 789-2020

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name ____

Patient address ____

Patient Phone number____

I authorize the professional office of my optometrist named above 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. Description of the information to be released____

2. Dr.____

3.The urpose for the release____

4.Expiration date or event____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how to request access to your identifiable health information, and how we may respond. Basically, you simply need to send a written request to the office contact person listed at the top of this form to initiate the process.

If you sign this authorization, you can revoke it later. The exceptions to this are 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. Send this note to the office contact person listed above. When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

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