ClearVue Eye Care
114 N. Sunrise Ave. Ste. C2 Roseville, CA 95661
T: 916-786-2212 F: **916-786-2393**
www.clearvue.org staff@clearvue.org

Dr. Aaron Lech ☐
Dr. Thomas Swanson ☐
Dr. Leanne Liddicoat ☐
Dr. Lisa Hornick ☐

AUTHORIZATION FOR RELEASE OF INDENTIFYING MEDICAL RECORDS & HEALTH INFORMATION

Patient Name____ DOB_____/______/_________

Mobile #(____)________________ Home #(____)_______________ Work #(____)_________________

Address_____________________________________City________________State____Zip__________

PLEASE NOTE: REPRODUCTION AND MEDIA FEES MAY BE CHARGED FOR MEDICAL RECORDS

The above patient authorizes records disclosure to: ☐ClearVue Eye Care ☐other *(fill in below)*

Name/Facility/Doctor Name________________________Phone(___)________Fax(___)__________

Address_____________________________________City________________State____Zip__________

Please select delivery method: ☐ **Please fax records** ☐ **Please mail records**

Dates and Type of information to disclose:

- ☐ 2 years prior from last date seen, including last exam
- ☐ Dates Other:_________________________________
- ☐ Specific Information Requested:
  ____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (VA Med Center, etc)
- ☐ Referral for Care
- ☐ Other______________________________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date signed below.

I understand that the information in my health record may include information relating to sexually transmitted disease, including acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral/mental health services, and treatment for drug and/or alcohol abuse.

I understand that: I may revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the health information management department. My revocation will not apply to information that has already been released. The revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization making disclosure.

Unless revoked, this authorization will expire on the following date:_________________, or 1 year from the date signed.
I have read the foregoing and acknowledge that I am familiar with and understand all the terms and conditions.

X____ ____________________________

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation or such status)

Date

____ ____________________________

Printed Name

Relationship / Capacity to Patient

____

Address & telephone number of Authorized Representative ***(if different from the Patient address at the top of the page)***