VISION SOURCE

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Virginia Eyecare Center, PC
9314A Old Keene Mill Road
Burke, VA 22015
703.569.3131
Anne Meccariello, OD, Privacy Official

Patient Name _____

Patient Address _____

Patient Phone Number _____

I authorize Virginia Eyecare Center, PC to release health information identifying me to the following:

_____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices*.

When your health information is disclosed under 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.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient