**AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**A.** Patient Name: _____ Date of Birth: _____
Last 4 of Social Security: _____ Phone Number: _____
Street Address: _____
City: _____ State: _____ Zip: _____

**B.** I authorize Virginia Eyecare Center to:

☐ **Release medical information to:**
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

☐ **Receive information from:**
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

C. Purpose of Disclosure: _____

D. Date(s) of Service and specific information to be disclosed:
☐ Exam Summary ☐ Test Reports ☐ Prescription(s) ☐ Discharge Instructions

☐ Other(Specify): _____

E. This authorization will expire: ☐ 60 days from date of signature ☐ Other (specify)_____

F. Fees (Virginia Eyecare Center use only):
1. Prescription copies and copies of medical records sent directly to a physician or optometrist will be provided at no charge.
2. A fee will be charged to the patient or patient's personal representative as follows:

| | | | |
|---|---|---|---|
| Patient record | $15 | Family Records | $25 |
| Via the Patient Portal | | | |
| Patient record | $10 | Family Records | $20 |

G. Statement of Understanding:
- I may revoke this authorization at any time in writing, although such a revocation will not apply to information already used or disclosed in response to this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I understand and acknowledge that this authorization extends to use and/or disclosure from my medical record, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS, and/or may include results of an HIV test or the fact that an HIV test was performed.
- Virginia Eyecare Center will not condition the provision of treatment, payment, enrollment, or eligibility for benefits based on the execution of this authorization.

× _____
Signature of Patient or Person Authorized to Consent

× _____
Date Signed

× _____
Printed Name

× _____
Relationship, If not the patient

Thank you for your cooperation.

Virginia Eyecare Center
9314-A Old Keene Mill Road Burke VA 22015
Phone: (703) 569-3131 Fax: (703) 451-9291

Email: Eyes@VirginiaEyecare.com

VIRGINIA EYECARE CENTER
MEMBER OF VISION SOURCE

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