

**AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**  
**Releasing records to the patient or guardian**

A. Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

B. Last 4 of Social Security: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

C. I authorize Virginia Eyecare Center to:

**Release medical information to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

D. Purpose of Disclosure: \_\_\_\_\_

E. Date(s) of Service and specific information to be disclosed:

Whatever the doctor determines is necessary to properly transition your care (recommended)

Other(Specify): \_\_\_\_\_

F. This authorization will expire:  60 days from date of signature  Other (specify) \_\_\_\_\_

G. Fees (Virginia Eyecare Center use only):

Records via the patient portal: \$10

Family Records via the patient portal: \$20

Paper Records: \$20

Family Paper Records: \$30

H. 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  
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Email: [Eyes@VirginiaEyecare.com](mailto:Eyes@VirginiaEyecare.com)

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