20
ON-SITE OPTOMETRY
20

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: ______________________ **Date of Birth:** ______________________

Phone Number: ______________________ **Address:** ______________________

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<table>
<tr>
<td colspan="3">I, ______________________ , authorize <u>2020 On-site Optometry</u> to release health record information for:
______________________ to:
(patient name or self)

____
(Name of person or facility receiving information)</td>
<td colspan="2">The purpose of this release is for:
❏ Receiving continued care at 2020
❏ Consultation/referral
❏ Legal
❏ Personal
❏ Other</td>
</tr>
<tr>
<td colspan="5">Please specify the health information you authorize to be released:
Type(s) of health information: ______________________
Date(s) of treatment: ______________________</td>
</tr>
<tr>
<td>Would you like the records to be:
❏ Faxed
❏ Mailed
❏ Secure electronic email</td>
<td colspan="2">☐ Please send the records to:
Name: ______________________
Address: ______________________
____
Phone: ______________________
Fax: ______________________</td>
<td>OR</td>
<td>☐ Send records to:

2020 On-site Optometry
190 Dorchester Ave.
Boston, MA 02127
Phone: (617) 356-8117
Fax: (617) 249-0621</td>
</tr>
</table>

NOTICE:

2020 On-site Optometry and other health organizations are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS:

- This authorization to release health information is voluntary. Treatment, payment, and eligibility for benefits may not be conditioned on signing this Authorization except for the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.
- This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Health Information Officer, at 2020 On-site Optometry, 190 Dorchester Ave., Boston, MA 02127. The revocation will take effect when 2020 receives it, except to the extent that others or we have already relied on it.
- You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, this Authorization expires: ______________________ (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

______________________ Print name ______________________ Date

______________________ Signature (Patient, Parent, Guardian) ______________________ Relationship to Patient (Parent, Guardian, or Patient Representative)

For internal use: Information release: Initials ______________ Date ______________

Copy of Authorization to patient: Initials ______________ / Authorization Revoked Date ______________