AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Ohana Optometry
1895 Mowry Ave. #117
Fremont, CA 94538
(510) 797-8770
Jamie Wong, O.D., Privacy Official

Patient Name _____

Patient Address _____

Patient Phone Number _____

By signing this form, I authorize Ohana Optometry to release health information, medical records or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.

Release my protected health information to the following physician/person/facility/entity:
Name _____
Address _____
City/State/Zip Code _____

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 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