

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Longview Eye Associates, PA
1506 Judson Rd.
Longview, TX 75601
(903)758-8832
Cindy Patterson, Privacy Official

Patient Name _____
Patient Address _____
Patient Phone Number _____

I authorize Longview Eye Associates, PA to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions:

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