Dr. Matt Hesse, OD
78 Barnes Dr, Monticello, KY 42633
(606) 348-3355; Fax (606) 348-5665
www.visioncarepsc.com; info@visioncarepsc.com

Authorization Form for Release of Information

Attending Doctor:_____

Section I:

I, _____, hereby agree that the above named doctor may disclose any and all information concerning my eye and visual status, while acting in a professional capacity, waiving all provisions of law to the contrary, including photographs.

Section II – Health Information

I specifically give permission for the above named doctor to release the following:

- ☐ Exam records personally created
- ☐ My eyeglass and/or contact lens prescription
- ☐ Exam records and/or letters sent to or from doctors I was referred to
- ☐ My patient history form
- ☐ Order information from my last material purchase from your office

Form of Disclosure:

- ☐ Electronic copy or access via a web-based portal
- ☐ Hard copy

Section III – Reason for Disclosure:

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish the reasons for sharing, write “at my request”.

_____

_____

_____

Section IV – Who Can Receive My Health Information

I give authorization of the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name_____

Organization_____

Address_____

I understand that the person(s)/organization(s) listed above may not be covered by state/federals rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid: (Check as appropriate)

□ a) From _____ to _____

or

□ b) All past, present, and future periods

or

□ c)The date of the signature in section VI until the following even: _____

I understand that:

- I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to the above named healthcare provider.
- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI- Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____

_____