Mary Anne C. Murphy, OD
Shira L. Pipkin, OD
Marisa A. Perez- Wilson, OD
Tracy L. Aigner, OD
Carrie M. Burleson, OD

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Information Requested To Be Released From/To:____________________________________

Patient Full Name____

Patient Current Address: ____

Patient Previous Address: (if applicable) __________________________________

Patient Phone number: (_______)______________________________________

Patient DOB: _______/________/________

I authorize the professional office of my provider named above to release the specific health information described below identifying me (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) only for the purposes and parties described below under the following terms and conditions:

- Indicate specific information to be released; ☐ MEDICAL , ☐ FINANCIAL , or ☐ OTHER (specify)
  ____
- Information may be RELEASED FROM/TO the following persons or entities; **Front Range Eye Associates, P.C. ATTN:** ☐ Dr. Murphy ☐ Dr. Pipkin ☐ Dr. Perez-Wilson ☐ Dr. Aigner ☐ Dr. Burleson
- Information to be released for the following purpose(s); ☐ CONTINUITY OF CARE or (specify)_______
- Authorization will remain in effect from the date signed below until the specified expiration date or event; or ☐ NO EXPIRATION DATE or (specify date or event) _____/_____/________; ____________________

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have before deciding to sign this authorization. Our Notice of Privacy Practices explains how to request access to your identifiable health information, and how we may respond. Basically, you simply need to send a written request to the office to initiate the process.

If you sign this authorization, you can revoke it later. The exceptions to this are if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the office address listed above.

If we are releasing information on your behalf, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

We will not receive a financial benefit from disclosing health information about you.

I HAVE READ AND UNDERSTOOD THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: ______________________________ Date:________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: ___________________________ Print Name: ____________________

Source of Authority: ________________________________

CLINIC USE:	OFFICE USE:
Dr Review Notes: ____________________	TO: ________________ P: __________
	1st: ________ 2nd: ________ F: __________
FU w/ PT: ☐ Y ☐ N ☐ Phone ☐ Email	Staff Initials 1st: ____ 2nd: ________ ☐ FILE ONLY