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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____ Patient number _____
Address _____ Phone _____
City _____ State _____ Zip _____

I authorize the professional office of my optometrist named above to release and/or receive health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Description of the information to be released:
2. To whom may the information be released [name(s) or class(es) of recipients]:
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date for the release (if any):

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. If you sign this authorization, you can revoke it later. If you wish to revoke your authorization, you must do so in writing and submit it to the address listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/ she wishes. State or federal law may determine this possibility.

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

Dated _____ Patient signature _____

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 _____