

Authorization to Release Medical Information



3293 N Milwaukee St
Boise, ID 83704
P: 208-322-2020 F: 208-322-1192

IMPORTANT PLEASE READ: This form authorizes your health care provider to release health information regarding your care of treatment to the individual or organization you identify as set out below:

Patient Information

Patient Name: _____
DOB: ____/____/____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize Boise Vision Care to: (check one)

Provide records to: _____

P: _____ F: _____

Obtain records from the entity listed below:

Purpose of the Request:

At request of patient or patient representative

 Other: _____

Records to be released from: Boise Vision Care Entity Listed Below

Office: _____
Address: _____
Phone: _____

Please release the following information: (please check minimum information needed to achieve purpose)

- | | | |
|--|--|--|
| <input type="checkbox"/> Eyeglasses Rx | <input type="checkbox"/> Contact Lens Rx | <input type="checkbox"/> Copy of last exam |
| <input type="checkbox"/> Visual fields | <input type="checkbox"/> OCT III Images | <input type="checkbox"/> Retinal Photos |
| <input type="checkbox"/> All records | <input type="checkbox"/> Other: _____ | |

I understand this release may include disclosure of information relating to treatment for alcohol/substance abuse, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), sexually transmitted disease (STD), or for psychiatric treatment or counseling, unless I specify otherwise below:

Please do not release any information concerning treatment for the following: _____

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN BASED UPON IT. THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED: _____

Information used or disclosed because of this authorization may be further disclosed by the recipient and therefore no longer protected.

Date: _____ Signature: _____
Patient
Signature: _____ / _____
Parent/Guardian Relationship
If patient unable to sign: _____ / _____
Witness Reason