TURLOCK EYECARE
OPTOMETRIC CORPORATION

Drs. Hamel, Robillard, Torossian & Li
2020 Colorado Ave. Ste. A Turlock, CA 95382
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PH - 209-667-6211 F - 209-667-2574

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:_____Patient DOB:_____

I authorize: (Provider/Facility who holds PHI):_____

To release health record information for: Patient Name:_____ DOB:_____

To: (Provider/Facility to receive information): _____

The purpose of this release for:

- ☐ Treatment
- ☐ Eye care management
- ☐ Eyewear or Contact Lens RX
- ☐ Billing or Insurance Purposes
- ☐ Other _____

Information to be released:

- ☐ Recent chart notes
- ☐ All chart notes
- ☐ Billing Information
- ☐ Eyewear or Contact Lens RX
- ☐ Other_____

I would like the records to be:

- ☐ Faxed: _____
- ☐ Mailed:_____
- ☐ Picked up: By _____
- ☐ Please send the records to: _____
- ☐ To: **Turlock Eyecare** (Drs Hamel, Robillard, Li or Torossian) - (Address/Fax at top of document)

I have read and understand this form. I am voluntarily signing and acknowledging the health information to be disclosed as stated above. I understand the recipient often has no legal duty to protect its confidentiality. I understand I may revoke this at any time in writing, but any previously disclosed information will remain per this authorization.

By signing below, I confirm the release of my information to the entities listed, and I attest the information listed is, to the best of my knowledge, current and accurate. ***This release expires 90 days after it is signed.***

Signature: _____ Date: _____

If a personal representative on behalf of the individual signs this authorization, complete the following and attach a copy of legal authority if applicable.

Representative's Name:_____Relation to the Patient: _____