



Drs. Hamel, Robillard, & Li
1199 Delbon Ave. Ste. 4 Turlock, CA 95382
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, or Li) - (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 (or parent/guardian for a minor) 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: