ENVISION FAMILY EYECARE PLLC
AUTHORIZATION FOR RELEASE OF INFORMATION

PHONE: 865-982-6110 FAX: 865-977-7243

This authorization for release of protected health information is provided by Envision Family Eyecare PLLC (the "Practice"). For information about how your medical information may be used or disclosed, please see the Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer of the Practice. The Notice is also posted at the Practice's offices.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED.**
- **WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION.**
- **WE WILL PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

I, (Print Patient's Name)________________________________, Date of Birth ____________________ do hereby authorize Envision Family Eyecare, PLLC to obtain, use, disclose or receive my individually identifiable health information as described below from ______________________________________. I understand that this authorization is voluntary. I understand that information released under this authorization may be disclosed by the recipient of the information and may no longer be protected by state and federal law.

ATTENTION: PATIENT OR PATIENT REPRESENTATIVE PLEASE INITIAL AND COMPLETE ANY OF THE APPLICABLE OPTIONS BELOW

________ **A ALL MEDICAL RECORDS:**

I authorize the Practice to release my complete medical record (this may contain treatment notes regarding radiology, pathology ***including HIV test results and genetic testing information***, immunization, procedure(s), ***alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2***, and other common medical record documentation made by the physician, nurse or other ancillary personnel) for the entire time I was treated by the Practice to the following office, family members or friends who contact the Practice for purposes of providing them with information related to my treatment and/or payment obligations:

Name: ________________________________ **Relationship:**____________________________

__________**B SPECIFIED MEDICAL RECORDS:** (for example, for disclosure of specific information to a school official)

I authorize the Practice to release the following types of records: (description of records to be released) ____, for information collected/services provided to me by the Practice during the time period of:____. I authorize the Practice to release this information to the following persons: _______________________________________ for the purpose(s) of ____________________________________.

__________**C MEDICAL RECORDS TO MY EMPLOYER**

I authorize the Practice to release the following types of records: (description of records to be released) ____, for information collected/services provided during the time period of :____. I authorize the Practice to release this information to my **employer** for the purposes of processing **FMLA forms, return to work or any other paperwork or any other information** that needs to be reported to my employer.

Employer's Name:________________________________
Employer's Address:______________________________
Employer's Telephone:____________________________
Employer's Fax:_________________________________

______________________________________ ____________________
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of patient's representative____
Relationship to the patient:____

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