BURKHARDT EYECARE

A MEMBER OF Vision Source

www.burkhardteycare.com

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: ____ DOB: _____________________

Patient Address: ____

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Patient Phone: ___________________________

I authorize the professional office of my doctor/clinic: **Gary J. Burkhardt, OD DBA Burkhardt Eyecare** to release 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: Copies of most recent records and/or summary of previous eye and health conditions and treatments, including all medical, eyeglass and contact lens Rx information.
2. To whom the information may be released (check one below):

____ To me, the Patient (or guardian if patient is a minor), OR

____ Other Eye Care Office

Name:
Address:
Fax Number:

3. The purpose(s) for the release: Patient is seeking eye care services from, and establishing a patient relationship with, the above doctor/clinic for continuity of care.

I HAVE READ AND UNDERSTAND THIS FORM AND 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: ____________________________________

*PLEASE ALLOW 2-4 weeks for information to be sent.