Holly Andersen, O.D.
Megan Baureis, O.D., Privacy Official
100 E. Joyce, Suite 104
Fayetteville, AR 72703
Phone: (479) 966-4232 Fax: (479) 966-4251
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Authorization for Release of Identifying Health Information (HPI)

Patient Name: _____ Date: _____

Patient Address: _____

Patient Phone #: _____ DOB: _____

The professional office named above is authorized to receive health information from the following clinics:

1._____

2._____

3._____

It is completely your decision to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have on file, before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office contact person, listed above, to initiate the process.

If you sign this authorization, you can revoke it later, except if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed above.

When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes. We will not receive a financial benefit from disclosing this health information about you.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above when needed.

_____ _____ _____
(signature) (print name) (date)

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
(Relationship to Patient) (print name)

Source of Authority: _____ _____