Dr. John H. Ackerson, O.D.
736 W. 100 S. Suite 2
Heber City, UT 84032
(435) 657-1212
Fax: (435) 657-9522

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____

Information Requested_____

Information Released To _____Authorization Expires_____

I authorize the professional office of my optometrist named above, 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. Detailed description of the information to be released;
2. To whom may the information be released;
3. The purpose for the release;
4. Expiration date or event;

It is completely your decision whether or not to sign this authorization. You can also review your health information that we have before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how to request access to your identifiable health information, and how we may respond. Basically, you simply need to send a written request to the office contact person listed at the top of this form to initiate the process.

If you sign this authorization, you can revoke it later. The exceptions to this are 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 IN THIS FORM.

Patient or Guardian_____ Dated: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient.

Relationship To The Patient _____

Please Print Your Name_____

Please FAX the information Requested to Dr. Ackerson at 435-657-9522