AUTHORIZATION TO ACQUIRE IDENTIFYING HEALTH INFORMATION

Patient Name _____

Patient Date of Birth _____

The doctor or facility named below is authorized to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, genetic information, and HIV infection or AIDS) under the following conditions:

Please list doctor's name, facility name, and office phone number:

_____

_____

_____

Information to be released:

□ Last Exam Record □ Glasses Prescription □ Contact Lens Prescription

□ All Medical Records □ Other: Please list specific information to be released

_____

_____

Reason for the release: At the request of the above named individual

Name of recipient: Dr. Greg Pientka, Palm Beach Eyes of Boynton Beach

Termination date for authorization:

□ No expiration □ 90 days from the date of this authorization □ Specific date_____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices*.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I have read and understand this form. I am signing it voluntarily.

_____ _____

Patient Signature (Parent or Guardian) Date

_____ _____

Witness Signature Date

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