REQUEST FOR RELEASE OF HEALTH INFORMATION

Windham Family Eye Care PLLC
63 Range Rd Suite 104
Windham, NH 03087

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

(NOTE: This form cannot be used to authorize a release of HIV-related information.)

Patient Name: _____
Last ,First ,M.I.

Patient Address: _____
No & Street City State Zip

Date of Birth: _____ Phone #: ( ) _____

INFORMATION TO BE DISCLOSED:

__ Record of last exam __ Spectacle Prescription __ Contact Lens Rx

RECIPIENT: Name of entity to whom the Practice may disclose my health information and address to which my health information should be delivered:

Jennifer Shanley, O.D.
Windham Family Eye Care PLLC
63 Range Rd Suite 104 Windham, NH 03087
Tel: (603) 893-1500 Fax: (603) 952-4981

TERM: This Authorization will remain in effect from the date of this Authorization until the Practice fulfills the request. By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s) ("At the request of the patient" is sufficient if the patient is initiating this Authorization):

At the request of the patient.

I understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization , the Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization of applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me; except, however, if my treatment at the Practice is for the sole purpose of creating PHI for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization. If my treatment is related to my participation in a research study, I understand that the Practice may refuse to treat me if I do not sign this Authorization. I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the Practice's Office Manager at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation. I have read and understand the terms of this Authorization.

I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

x_____
Signature of Patient or Legally Authorized Representative Date