I, ______________________________, direct Ridgway Eyecare Center to disclose and release my protected health information described below to:

Name: *Relationship:*

____________________ ______________________________

____________________ ______________________________

____________________ ______________________________

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - o Mental health records
  - o Communicable diseases (including HIV and AIDS)
  - o Alcohol/drug abuse treatment
  - o Other (please specify): ____________________________

This authorization shall be effective until (Check one):

- X All past, present, and future periods, OR
- o Date or event:____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

____________________ Name of the Individual Giving this Authorization

____________________ Signature of the Individual Giving this Authorization

____________________ Date of birth

____________________ Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

FORM #001