SIRI
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724 Cambridge Plaza

Cambridge, MD 21613

Phone: 443-515-9278/ Fax: 8339402191

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Names: _____

Patient Email: _____

Patient Home Address: _____

Patient Best Contact Number: _____

I authorize the professional office of my optometrist named above to release health information identifying me [including if applicable, my eyeglass/ contact lens prescriptions, information about my ocular health, HIV/AIDs, substance abuse treatment and my mental health] under the following terms and conditions:

1. Detailed description of the information released:
2. To whom may the information be released [name (s) or class (es) of recipients]:
3. The purpose (s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as a purpose, if desired by the individual):
4. Expiration date of the event relating to the individual or purpose for the release:

It is completely your decision whether to sign this authorization form or not. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is 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 the note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND I UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Dated: _____