Lifetime EyeCare
Family Vision Center

Vision Source™

Dr. Stephanie P. Layman
Optometrist

Dr. Alisa J. Lindley
Optometrist

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____

Date of Request: _____

Patient Date of Birth: _____ Patient Phone: _____

I hereby authorize _____, it's physicians, and/or staff to release health information identifying me and/or the minor for which this form applies (including, if applicable, information about HIV or AIDS, information about substance abuse, and information about mental health status/treatment) to:

Lifetime EyeCare

2043 Greystone

Jackson, Tn 38305

Phone (731) 668-3424 Fax (731) 668-3425

under the following terms and/or conditions:

* Description of the information to be released (when applicable);
* Purpose(s) for the release (if the authorization is initiated by the Patient, it is permissible to state "at the patient's request" as the purpose;
* Expiration date or event relating to the individual or purpose for the release.

It is your decision whether or not to sign this authorization Form. We cannot refuse to treat you based upon your decision to sign this form. If you sign this authorization, you can revoke it later. If we have already acted in reliance upon the authorization, however, the revocation is not valid. If you revoke your authorization, send a written request ot the contact person named at the top of this form. When your health information is disclosed as provided in this authorization, the recipient may not have legal duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I have read and understand this form. I authorize the disclosure of my health information as described in this form. I further attest that I have the authority to sign this form if I am doing so as a personal representative of the patient listed above.

_____

Signature Date