Lifetime Optometric
1111 East Herndon Avenue, #101
Fresno, CA 93720
Telephone (559) 432-2200 Fax (559) 432-2203

PATIENT AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient:_____DOB:_____

Date of Request: _____Phone Number:_____

I, patient undersigned below, authorize:

Lifetime Optometric
Margie Recalde, OD, Michael Hayashi, OD, Staci Hamamoto, OD
1111 East Herndon Avenue, #101
Fresno, CA 93720
Fax (559) 432-2203 • Telephone (559) 432-2200

to (**PLEASE CIRCLE)** release / obtain my medical information and/or other information considered under the HIPAA privacy law to be part of the Designated Record Set to or from the following contact or entity:

Provider Name:_____

Telephone # _____Fax # (if applicable) _____

Please send the following: _____Spectacle Prescription _____Contact Lens Prescription _____All Records on File

_____Records from last 3 years _____Other (please be specific)_____

This authorization will expire one year from the date listed below or on _____ or occurrence of specified event at which time this authorization to use or disclose the identified health information expires, but no later than **one year** from the date listed below.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I understand that Lifetime Optometric may charge a $25 fee for the costs of copying, mailing, or other supplies and services associated with this request when a patient requests his or her medical records to be released directly to the patient or patient representative. If Lifetime Optometric is sending the records directly to a doctor's office, there will not be a service charge.

I understand that I may revoke this authorization at any time provided that I do so in writing and deliver the revocation to Lifetime Optometric, 1111 E. Herndon Ave, Suite 101, Fresno, CA 93720.

Signature of Patient or Patient Representative

_____Date_____

Printed Name of Patient Representative and Legal Relationship to the Patient

_____