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Release of Personal Health Information Form and Policy

Cottonwood Vision Care, LLC, D/B/A Orbit Eyecare & Optical, will release medical information to individual patients based on the following policy, and in accordance with local and federal regulations regarding the release of protected medical information: Upon request and completion of this form, a copy of a patient's current valid eyeglass or contact lens prescription will be provided to the patient by email, fax, mail, or in person at no charge to the patient, provided such prescription is not expired and all fees for the glasses and/or contact lens examinations and fittings are paid in full. Upon request and completion of this form, a copy of a patient's complete medical record will be provided at any time at a cost of $25 for the first 15 pages, and $0.25 per page thereafter. Medical records will only be copied and released in their entirety. Copies of medical records must be picked up in person and will not be mailed, faxed, or emailed. Patients or their legally-authorized representative must provide valid photo identification when copies of the records are retrieved. Copies of medical records will be provided within 30 days of submitting this signed request.

I, _____, hereby voluntarily authorize the disclosure of information from my medical record.

The information is to be disclosed by: _____

And provided to: _____

The purpose or need for this disclosure is for: _____

The information to be disclosed from my health record is:

☐ Glasses Prescription

☐ Contact Lens Prescription

☐ Entire Record

I understand that I may revoke this authorization in writing at any time. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event. I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 522a].

_____ _____

Signature (if under 18: parent/guardian signature) Date

Patient Identification:

Full Name: _____

Social Security Number: _____

Date of Birth: _____