

**THIS AUTHORIZATION MUST BE RETURNED WITH A SIGNED COPY OF THE  
PATIENT'S PICTURE ID  
AUTHORIZATION FOR RELEASE OF INFORMATION**

**Section A: Must be completed for all authorizations**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

Persons/Organizations providing the information:

Art Optical Contact Lens, Inc.  
3175 Three Mile Rd NW  
Walker, MI 49544

Persons/Organizations receiving the info:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific description of information (including date(s)): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name & Address (must include State) of Eye Care Practitioner where contact lens RX originated: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section B: Must be completed only if a health plan or a health care provider has requested authorization**

1. The health plan or health care provider must complete the following:
  - a. What is the purpose of the use or disclosure?: \_\_\_\_\_  
\_\_\_\_\_
  - b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes \_\_\_\_\_ No \_\_\_\_\_
2. The patient or the patient's representative must read and initial the following statements:
  - a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: \_\_\_\_\_
  - b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: \_\_\_\_\_

**Section C: Must be completed for all authorizations**

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on \_\_/\_\_/\_\_\_\_ (DD/MM/YY) Initials: \_\_\_\_\_  
or after all issues related to this event have been resolved.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials: \_\_\_\_\_

Signature of patient or patient's representative \_\_\_\_\_

Date \_\_\_\_\_

(Form MUST be completed before signing.)

Printed name of patient's representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_

***\*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION\****

***You may not use this form to release information for treatment or payment except  
when the information to be released is psychotherapy notes or certain research information.***