

***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.*