REQUEST FOR PREVIOUS RECORDS AND HIPAA AUTHORIZATION FORM

To: _____

From:

Casey Johnston, O.D.
Kassaundra Johnston, O.D., F.A.A.O
Pine Creek Vision Clinic
9475 Briar Village Pt., Suite 200 Colorado Springs, CO 80920
Phone: (719) 594-2020 Fax: (719) 694-8562

*Please send the following requested Information to the address or fax above.

Authorization for the Release of Identifying Health Information

Patient Name: _____ Phone Number: _____
Patient Address: _____ D.O.B. _____

The professional office/doctor named above in the "To:" section is authorized to release health information identifying the patient named above under the following terms and conditions:

1. Detailed description of the information to be released: _____
_____
2. To whom the information will be released: _____
( ) Dr. Casey Johnston ( ) Dr. Kassaundra Johnston
3. The purpose for the released: _____
4. Expiration date or event: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat the patient if you choose not to sign this authorization. You can also review your health information that we have on file, before deciding whether to sign this authorization. Our *Notice of Privacy Practices* explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office contact person, listed above, to initiate the process.

If you sign this authorization, you can revoke it later, except if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the office contact person listed above.

When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I hereby release the doctor or facility named above in the "To:" section from all liability and claims of any nature whatsoever pertaining to disclosure of information contained in my medical records.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.

Signature:_____ Date: _____
If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:
Relationship to Patient: _____ Name: _____
Source of Authority: _____