Member
American Optometric Association

GEORGE A. ROEBUCK, O.D.
DOCTOR OF OPTOMETRY

HIPAA RECORDS RELEASE FORM **date**_____

Authorization: I authorize_____

Healthcare provider to release records

For*(patient)*_____birthday_____

To use and disclose health information described below to_____

Healthcare provider receiving the records

Effective Period: Release any information including the diagnosis and medical records or any treatment, examinations or tests rendered for covered period *begin date*_____*to end date*_____

Authorizaton date: This authorization shall be in force and effect until _____(date) at which time this authorization expires.

The medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sing this authorization.

X_____

Signature of patient or personal representative

X_____

Printed name of patient or personal representative and his or her relationship to patient

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