TIMOTHY C. WISE, OD
AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization for release of protected health information is provided by Timothy C. Wise, OD (the "Practice"). For information about how your medical information may be used or disclosed, please see the Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer of the Practice. The Notice is also posted at the Practice's offices.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED .**
- **WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION.**
- **WE WILL PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

I, (Print Patient's Name) _____, Date of Birth _____ _____ do hereby authorize Timothy C. Wise, OD to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that information released under this authorization may be redisclosed by the recipient of the information and may no longer be protected by state and federal law.

ATTENTION: PATIENT OR PATIENT REPRESENTATIVE PLEASE INITIAL AND COMPLETE ANY OF THE APPLICABLE OPTIONS BELOW

_____ **A ALL MEDICAL RECORDS:**

I authorize the Practice to release my complete medical record (this may contain treatment notes regarding radiology, pathology ***including HIV test results and genetic testing information***, immunization, procedure(s), ***alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2***, and other common medical record documentation made by the physician, nurse or other ancillary personnel) for the entire time I was treated by the Practice to the following family members or friends who contact the Practice for purposes of providing them with information related to my treatment and/or payment obligations:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____**B SPECIFIED MEDICAL RECORDS:** (for example, for disclosure of specific information to a school official)

I authorize the Practice to release the following types of records: (description of records to be released) _____ _____, for information collected/services provided to me by the Practice during the time period of: _____ _____. I authorize the Practice to release this information to the following persons: _____ for the purpose(s) of _____.

_____**C MEDICAL RECORDS TO MY EMPLOYER_**

I authorize the Practice to release the following types of records: (description of records to be released) _____ _____, for information collected/services provided during the time period of : _____ _____. I authorize the Practice to release this information to my **employer**

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for the purposes of processing **FMLA forms, return to work or any other paperwork or any other information** that needs to be reported to my employer.

Employer's Name:_____
Employer's Address:_____
Employer's Telephone:_____
Employer's Fax:_____

ATTENTION: PATIENT OR PATIENT REPRESENTATIVE PLEASE INITIAL THE FOLLOWING:

I understand that the Practice may wish to contact me for purposes related to my treatment such as to remind me of appointments, leave messages that the physicians or nurse need to speak with me, to discuss financial/billing businesses, or to indicate other necessary contacts.

Please Initial

_____ Yes, **I authorize the Practice to contact me at the telephone numbers I have provided. I understand and authorize the Practice to leave me a voicemail message in the event that I am unavailable.**

_____ No. I do not agree to these contacts. Do not leave a message.

I understand that I may withdraw my authorization in writing to the Privacy Officer of the Practice at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire ***five (5) years from this date.*** I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of patient's representative_____
Description of the Representative's authority to act for the patient_____
Relationship to the patient:_____