REQUEST FOR ACCESS AND AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

				DATE OF REQUEST
PATIENT LAST NAME	FIRST NAME			DATE OF BIRTH:
PATIENT ADDRESS	CITY	STATE	ZIP	EMAIL
TELEPHONE - HOME	TELEPHONE - OFFICE			TELEPHONE - MOBILE

I hereby authorize the release (use of disclosure) of my individually identifiable health information as described below. I understand that authorizing the disclosure of this health information is voluntary.

1. The Vision Health Institute (VHI) may not condition it's providing of health care on whether copies to/from individuals or organizations are released as I request. I understand that I can refuse to sign this authorization to receive health care benefits, treatment, payment or normal practice operations.
2. VHI may by law refuse to allow access to or disclosure of all or part of my protected health information. If access or disclosure is denied or refused, VHI will not release the information as requested in this authorization, and I will be notified of the denial/refusal in writing.
3. I may revoke this authorization by notifying VHI in writing, requesting to revoke this authorization. Revoking this authorization will not affect any actions already taken based upon this authorization before receiving the revocation.
4. If this authorization is for marketing purposes, I understand that VHI will not be paid or receive anything of value for providing this information.
5. I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by the privacy law federal regulations. By specifically authorizing the release of HIV/aids related alcohol or drug treatment, or mental health treatment information that the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
6. This authorization will expire on _____/_____/_____. If no expiration date, this authorization is valid for information created within 12 months after the date of signature. I understand it is my responsibility to notify VHI to initiate follow-up requests based upon this standing authorization.
7. I shall receive a copy of this form after I sign it if the request for disclosure was initiated by VHI. I may see and copy the information described on this form upon request.
8. Requests may be subject to an $1.00 administrative fee per page. Please allow a minimum of 7 business days to process your request

I hereby Release Medical Information TO_____ FROM _____	This information is being _____ Released TO _____ Requested From
Vision Health Institute (VHI)	Organization Contact
400 N. Bumby Avenue	Address
Orlando, Florida 32803	City, ST, ZIP
PH: (407) 893-6222	Phone
Fax: (407) 896-4200	Fax
Email: MyVisionHealth@gmail.com	Email

I hereby authorize disclosure of the health information for the herein named patient.: (check all that apply)

- ☐ All health care information
- ☐ Eyeglass prescription(s)
- ☐ Specific healthcare information (Specify)
- ☐ Other administrative and billing information or diagnostic tests: specify date(s):
- ☐ Contact lens prescription(s)
- ☐ Pharmaceutical prescription(s)

The Vision Health Institute ☐ MAY ☐ MAY NOT use or disclose health care information regarding testing, diagnosis, or treatment for:

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Other
- ☐ Drug and/or alcohol use

Patient or legally authorized individual signature	Date
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)