HELLERSTEIN & BRENNER
VISION CENTER, P.C.

LYNN F. HELLERSTEIN, O.D., F.C.O.V.D., F.A.A.O. • TRICIA BRENNER, O.D. • JINA C. SCHAFF, O.D. • SARA K. GRELL, O.D. • AMY E. ELSILA, O.D.

Authorization for Release and/or Disclosure of Health Information

I authorize the disclosure of my personal health information to the persons/entities as described below. I understand this authorization is voluntary, and made to confirm my directions. I understand that once the information is disclosed, it may be re-disclosed and no longer protected by federal privacy regulations. I hereby give permission to Hellerstein & Brenner Vision Center, P.C. Greenwood Village, CO to disclose my personal health information in the manner described herein.

PATIENT'S INFORMATION		
Name:		Hellerstein & Brenner Vision Center, P.C. Greenwood Village, CO Medical Record #:
Birthdate:	Contact Phone Number:	Request Date:

Records From:	
Person/Facility:	Phone: Fax #:
Address:	

Records To:	
Person/Facility:	Phone #: Fax: #:
Address:	

PERSONAL HEALTH INFORMATION TO BE DISCLOSED

1. Specify records to be released and /or disclosed:

□ General Medical Information (from_____________ to ________________)

□ Information Regarding Specific Injury or Treatment (from ________________ to ___________________)

□ X-Ray/Laboratory Results of (from ______________ to ___________________)

□Mental Health (from ______________ to ________________) Initials of Patient or Representative _______________

□Alcohol/Drug (from ___________________ to _____________) Initials of Patient or Representative _______________

□HIV Test Results (from ______________ to ___________) Initials of Patient or Representative _______________

□ Other (specify): ____

2. Your request will be deemed to include any information related to sexually transmitted disease, alcohol or drug use or treatment, or mental health/psychology/psychiatry that may be within your above request, unless you specifically state your objection here:

Right to Revoke: I understand that I may revoke this authorization in writing at any time. I understand my revocation will NOT affect any disclosures that occurred before Hellerstein & Brenner Vision Center, P.C. Greenwood Village, CO received and processed a written notice of revocation. I understand that if I did not specify duration and if I do not revoke it, this authorization will expire one year from the date of signature below. To revoke this authorization, I understand that I must send a written request to Hellerstein & Brenner Vision Center, P.C. 7400 E. Orchard Road, Suite 175-S Greenwood Village, CO 80111

ACKNOWLEDGEMENT

Please sign and date: I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Hellerstein & Brenner Vision Center, P.C. Greenwood Village, CO to release nonpublic personal health information. I understand that Hellerstein & Brenner Vision Center, P.C. Greenwood Village, CO will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

By: ______________________________________ ____________________________________ _________

Patient's Name (Print) Patient's Signature Date

If you are not the Patient, please also complete, sign and date below. Check the box that describes your relationship to the Patient. Please attach proof or your relationship to the Patient (e.g. Power of Attorney, legal guardian)

By: ______________________________________ ____________________________________ _________

Patient's Name (Print) Patient's Signature Date