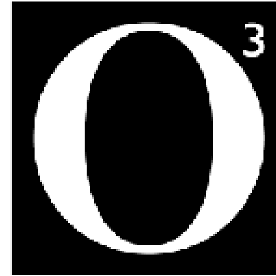


# CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

**I,______________________________________, born________________________,**
patient name Date of birth

**authorize and request:** **to furnish to:**

______________________________ ______________________________
Specify Practice/Facility or Physician Name Specify recipient of patient records

______________________________ ______________________________

______________________________ ______________________________

**the following information:______________________________________________**
Specify all or what portion of records

**Purpose of disclosure:__________________________________________________**
This information is released for this purpose and this purpose only

**I understand that if my medical record contains information concerning HIV (AIDS) or drug or alcohol abuse, those portions of my medical record are protected by state or federal law. I hereby release and forever discharge Discover Vision Centers, the physicians and employees, or agents from any liability arising out of the release of my medical record as specified above and pursuant to this signed authorization.**

**This consent is subject to written revocation at any time*, except to the extent that the disclosure has already taken place in reliance on it. If not previously revoked, this consent will terminate on:____________________. If left blank, this consent expires in one year.**

______________________________ ______________________________
Signature of patient month day year

______________________________ ______________________________
Signature of parent, guardian, or authorized representative Nature of relationship

______________________________
Witness

**Information disclosed as requested in this authorization may be subject to re-disclosure by the Recipient and may no longer be protected by the federal HIPAA rule.**

**Treatment may not be conditioned on signing this authorization unless treatment is research related and the authorization is for use or disclosure for such research.**

***Written revocation must be submitted to: Privacy Official, Discover Vision Centers, 4741 South Cochise, Independence, Missouri 64055.**

rec release 0507