AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

OPHTHALMIC ASSOCIATES OF BILLINGS, L.L.C.
4033 Avenue B
Billings, MT 59106
406-256-6000
406-256-9006 (fax)

PRACTICE NAME _____

Patient name _____

Patient address _____

Patient phone number _____

Patient date of birth_____

I authorize the professional office of my provider named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released;
2. To whom may the information be released; **Ophthalmic Associates of Billings, LLC**
3. The purpose for the release;
4. Expiration date or event;

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how to request access to your identifiable health information, and how we may respond. If you sign this authorization, you can revoke it later. The exception to this is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written letter telling us that your authorization is revoked. Send this letter to the office manager at the address listed above.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ _____
Dated Patient

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____
Relationship to Patient Print Name

_____
Source of Authority