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OPTOMETRIC RECORDS RELEASE FORM

Patient Name:____
Date of Birth:___________ Social Security Number:__________________
Other Names Records May be Under:______________________________
Records to be Released From:_____________________________________
Phone ________________________ Fax______________________________

I authorize the facility listed above to disclose my protected health information as described on this form to MOUNTAIN VIEW EYE CARE. I have read this authorization and understand what information will be disclosed, who may disclose the information and the recipient(s) of that information. I understand that when the information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

- **[ ] My entire optometric medical record. MAIL**
- **[ ] Last eye exam with most current spectacle and contact lens prescriptions FAX**

- **This authorization will expire on _________________. After this date, it can no longer be used to disclose my health information without first obtaining a new authorization form.**

I fully understand and accept the terms of this authorization.

PATIENT SIGNATURE____

DATE________________

WITNESS SIGNATURE____