REQUEST FOR RELEASE OF HEALTH INFORMATION

Dr. Tim Goldsmith
Dr. Wendy Goldsmith
Optometrists
Goldsmith Eye Care, PC
112 East Main St, PO Box 261
New Prague, MN 56071

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: _____
First M.I. Last

Patient Address: _____
Street City State Zip

Date of Birth: _____ Home Phone: (_____)_____

TRANFER RECORD FROM:

Doctor:_____ Fax:_____

INFORMATION TO BE DISCLOSED (Please send all that apply):

Eye Exam Information (up to last 3 years)
Office Visits (up to last 2 years)
Auxiliary Tests including but not limited to VF, GDX, and Pach
Contact Lens Information (including Prescription and Type of lens last fit)
Spectacle Prescription
Most Recent Frame and Lenses information

RECIPIENT: Name of person or class of persons to whom the Practice may disclose my health information:

Dr. Tim Goldsmith, Dr. Wendy Goldsmith
Optometrists
Goldsmith Eye Care, PC

Address to which my health information should be delivered:

Goldsmith Eye Care PC, 112 East Main St, PO Box 261, New Prague
Tel: (952) 758-2080 Fax: (952) 758-5922

TERM: This Authorization will remain in effect from the date of this Authorization until the Practice fulfills the request.

By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s) ("At the request of the patient" is sufficient if the patient is initiating this Authorization):

At the request of the patient.

I understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization , the Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization of applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me; except, however, if my treatment at the Practice is for the sole purpose of creating PHI for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization. **If my treatment is related to my participation in a research study, I understand that the Practice may refuse to treat me if I do not sign this Authorization.**

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the Practice's Office Manager at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.
I have read and understand the terms of this Authorization and I have had an opportunity to ask question s about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

_____

Signature of Patient or Legally Authorized Representative **Date**