

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name

Date of Birth

Patient Address

Patient Phone Number

I authorize the release of health information identifying me under the following conditions:



I authorize the office listed below to release all records and any pertinent information to Crystal Vision.

Office Name

Address

City, State, Zip

Phone

Fax



I authorize Crystal Vision to release all records and any pertinent information to the office listed below.

Office Name

Address

City, State, Zip

Phone

Fax

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign it. If you do sign, you may revoke it at any time by contacting our Privacy Official, noted in the Notice of Privacy Practices, via fax, email or letter.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Signature

Date

Representative Signature

Relationship to Patient



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Topeka, KS 66614
785.955.1519 | 785.480.2064 fax