Authorization

Use or Disclosure of Health Information

Vance Thompson Vision
3101 W. 57th St.
Sioux Falls, SD 57108
(877) 522–3937
(605) 361–3937
FAX: (605) 371–7035

VANCE THOMPSON VISION

Date Needed By _____ ☐ To be picked up ☐ To be mailed

PATIENT IDENTIFICATION

Name _____ Date of Birth _____
Address _____ Phone _____
City/State/Zip _____
Maiden/Previous Names/Nickname _____
Social Security Number _____

PROVIDER
(Who is releasing information?)

Provider/Facility Name _____ Phone _____
Address _____
City/State/Zip _____

DISCLOSE INFORMATION TO
(Where is the information sent?)

Name/Facility _____
Address _____
City/State/Zip _____
Phone _____ Fax _____
To assure confidentiality, it is the policy of Vance Thompson Vision to send reports via first-class mail. Vance Thompson Vision will transmit records via facsimile only when requested and expressly authorized by the patient.

INFORMATION TO BE DISCLOSED

☐ Clinic progress notes	☐ Lab data	☐ All records
_____ Physician's	☐ Pathology reports	☐Other
_____ Nurse's	☐ Radiology reports	_____
☐ Psyciatric evaluation	☐ EKG/cardiology reports	_____
☐ Psychological evaluation	☐ Immunization record	_____

PURPOSE OF DISCLOSURE
(Please be specific)

☐ Continuing medical care	☐ Consult	☐ Out-of-town move
☐ Insurance claim	☐ Legal	☐ Personal

☐ Other _____

For Marketing: *The disclosing organization _____ will or _____ will not receive compensation, monetary or otherwise, as a result of this use or disclosure.*

EXPIRATION DATE

This authorization will expire one year form the date of signature on _____

REVOCATION

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

AUTHORIZATION

I hereby authorize the above facility/provider to disclose medical information concertning the above named patient to the party identified in the section entitled "Disclose Information To." I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand thta once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

Signature of Patient/Representative _____ Date _____
Relationship to Patient (if signed by represenative) _____
Witness (optional) _____
Please supply proof of authority to act. For minors, proof only required if other than parent.

DISPOSITION

For Office Use Only:
Date Sent _____ Sent By _____
☐ Authority to act attached ☐ ID validated MR # _____