Authorization

Use or Disclosure of Health Information

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 ☐ Other ☐ Surgical notes _____ ☐ Lab/pathology reports _____ ☐ All records _____
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 from 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 concerning 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 that 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 # _____

FAX TO:

☐ **Sioux Falls, SD:** (605) 371-7035 ☐ **Omaha, NE:** (402) 401-6420 ☐ **South Sioux City, NE:** (531) 625-3940

☐ **West Fargo, ND:** (701) 639-7199 ☐ **Alexandria, MN:** (320) 762-8898 ☐ **Cedar Rapids, IA:** (319) 362-0655

☐ **Bozeman, MT:** (406) 624-6560 ☐ **Billings, MT:** (406) 294-1996 ☐ **Northern Colorado:** (970) 582-1176