Authorization

Use or Disclosure of Health Information

Date Needed By ____________________

☐ To be picked up ☐ To be mailed

Patient Identification

Name ____

Date of Birth _______________ Phone ____________________________

Address ____

City/State/ZIP ____

Maiden/Previous Names/Nickname _____________________________

Social Security Number ____

Provider (Who is releasing this 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/pathology reports
- ☐ Surgical notes
- ☐ All records
- ☐ Other ____

Purpose of Disclosure (Please be specific)

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

____

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 # ____

- ☐ **Sioux Falls, SD**
  FAX: (605) 371-7035
- ☐ **West Fargo, ND**
  FAX: (701) 639-7199
- ☐ **Bozeman, MT**
  FAX: (406) 624-6560
- ☐ **Omaha, NE**
  FAX: (402) 401-6420
- ☐ **Alexandria, MN**
  FAX: (320) 762-8898
- ☐ **Billings, MT**
  FAX: (406) 294-1996
- ☐ **South Sioux City, NE**
  FAX: (531) 625-3940