SACRAMENTO CONTACT LENSES & OPTOMETRY, INC.

SACRAMENTO
701 Howe Avenue, Suite G-48
Sacramento, California 95825
Fax (916) 921-5494
(916) 921-8080

ROSEVILLE
2150 Professional Drive, Suite 190
Roseville, California 95661
Fax (916) 789-1332
(916) 789-2020

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name ____

Patient address ____

Patient Phone number____

I authorize the professional office of my optometrist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Description of the information to be released____

2. Dr.____

3.The urpose for the release____

4.Expiration date or event____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how to request access to your identifiable health information, and how we may respond. Basically, you simply need to send a written request to the office contact person listed at the top of this form to initiate the process.

If you sign this authorization, you can revoke it later. The exceptions to this are if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed above. When your health information is disclosed as provided in 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. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

___________________________________ Patient Signature

____ Date

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Roseville, California 95661
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Authorization for Release of Medical Information

I,_________________________(patient), herby authorize **Sacramento Contact lenses and Optometry, Inc** to release personal health information. This information will be provided to _____________________(Doctor and/or Company), for the purpose of _________________ _________________________ (specific purpose for information is to be used).

The type of information that may be released and used by the Doctor and/or Company includes:
(Check where applicable and include dates as appropriate.)

□ Most recent history or physical exam results

□ Most recent history of contact lenses

□ Certification of Serious Health Condition, as required for leave under federal or state law

□ Medical information related to the disability of__________________________.

□ Medication list

□ List of Allergies

□ Other (specify) ____

This authorization is valid from________(start date) to_________(end date). If I fail to specify an expiration date, this authorization expires in 90 days after the date of my signature below unless previously revoked in writing, I understand that I have the right to revoke this authorization at any time by giving written notice to the Company or the provider/practitioner named above. Such revocation shall not apply to any information that has been released prior to revocation of the authorization.

I understand that authorizing the disclosure of my medical information is voluntary. I can refuse to sign this authorization. I further understand that I have the right to inspect and copy the information disclosed as a result of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, which may or may not be protected by federal or state confidentiality rules. If I have any questions about the disclosure of use of their information, I may contact Ginger Himelight, Privacy Manager or AJ Bennett, contact person.

____ ____________________
Signature of Patient or Legal Representative of Patient Date

If signed by Patient's Legal representative, describe your (legal representative's) authority to act:____