# Marciano Family Optometric

**A MEMBER OF** VISION SOURCE™

**DR. MARK MARCIANO, OPTOMETRIST · DR. BRANDEE O. MARCIANO, OPTOMETRIST**

## General Medical Records Release and Authorization for Use of Disclosure of Protected Health Information

Please complete the following information:

Patients Name: _____

Address: _____

_____

Phone: _____

DOB: _____

I authorize and request the disclosure of all protected information for the purpose for review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the follow:

☐ Spectacle Prescription ☐ Contact Lens Presciption ☐ All Records on File

☐ Records from last 3 years ☐ Other (please be specific)_____

_____

**Expiration of the Authorization:** (please initial one)

☐ 90 days after signature date ☐ No expirations ☐ On this date: _____

_____

**PLEASE OBTAIN INFORMATION FROM:**

_____
Name of Provider/Clininc/Organization

_____
Street Address

_____
City, State, Zip Code

Phone:_____Fax:_____

**PLEASE SEND INFORMATION TO:**

_____
Name of Provider/Clininc/Organization

_____
Street Address

_____
City, State, Zip Code

Phone:_____Fax:_____

☐ Pick up Record ☐ Mail Records ☐ Fax Records

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal laws. I understand the information released in response to this authorization may be re-disclosed to other parties. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Patients Signature (Parent or Legal Representative, if applicable) Date

_____ _____

Witness Signature Date

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