AUTHORIZATION TO RELEASE OR DISCLOSE HEALTH CARE INFORMATION

				DATE OF REQUEST
PATIENT LAST NAME	FIRST NAME			DATE OF BIRTH:
PATIENT ADDRESS	CITY	STATE	ZIP	EMAIL
TELEPHONE - HOME	TELEPHONE - OFFICE			TELEPHONE - MOBILE

I hereby authorize the release (use of disclosure) of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. This authorization will remain in effect for ninety (90) days, at which time authorization will expire unless revoked earlier. I understand that there may be a $1.00 administrative fee per page for all protected health information

I hereby Release Medical Information FROM:	**This information is being Released TO:**	
Vision Health Institute	**Organization**	
Drs. Perry, Perry and Associates PA	Contact	
400 N. Bumby Avenue	Address	
Orlando, Florida 32803	City, St Zip	
PH: (407) 893-6222	PH	
Fax: (407) 896-4200	Fax	
Email: MyVisionHealth@MyVHI.com	Email	

I Hereby Request and Authorize the Release of Medical Information FROM:		**This information is being Released TO:**
Organization		**Vision Health Institute**
Contact		Clinical Documentation Administration
Address		400 N. Bumby Ave.
City, St Zip		Orlando, Florida 32803
PH		PH: (407) 893-6222
Fax		FAX: (407) 896-4200
Email		EMAIL: MyVisionHealth@MyVHI.com

The Vision Health Institute may release or disclose the following health care information. The patient authorizes the release and disclosure of the following information (an administrative fee may be applied before the discharge of private health information: (check all that apply)

- Eyeglass prescription(s)
- Contact lens prescription(s)
- Other administrative and billing information or diagnostic tests: specify date(s):
- Specific healthcare information in my record:
- Pharmaceutical prescription(s)
- All health care information in my medical record

The Vision Health Institute MAY treatment for:	**MAY NOT use or disclose health care information regarding testing, diagnosis, and**
HIV (AIDS virus)	Psychiatric disorders/mental health
Sexually transmitted diseases	Drug and/or alcohol use

Reason(s) for this authorization (check all that apply):

- At my request
- For medical purposes
- At the request of the doctor
- Other

Patient or legally authorized individual signature	Date
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)

MY RIGHTS: I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or normal practice operations.). I may revoke this authorization by writing a letter requesting to revoke this authorization to the Clinical Administrator. Revoking this authorization will not affect any actions already taken by the practice based upon this authorization. If this authorization is for marketing purposes, I understand that the practice will not be paid or receive anything of value for providing this information. Once health care information is released or disclosed, the person or organization receiving it may release it.