IRONWOOD VISION CENTER
DANIEL N. GARN, O.D.
101 W IRONWOOD DR STE 181 COEUR D ALENE, ID 83814
PH. (208) 765-2200 FAX (208) 765-2217

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PATIENT
NAME_____DOB_____

PATIENT
ADDRESS_____

_____HOME PH#_____

I authorize _____(name of clinic) 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. Detailed description of the information to be released:

2. To DR. DANIEL N. GARN and IRONWOOD VISION CENTER.

3. The purpose(s) for the release (if authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

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.
If you sign this authorization, you can revoke it later. The only exception to your right to revoke is 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 attention of the office contact person listed at the top of this form.

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.

Signature_____Date_____

If you are signing as a personal representative of the patient, describe your relationship and source of authority:
Relationship to patient_____PrintName_____
Source of Authority_____