Authorization to Release Optometry Information

Dr. Channing A Baird and Associates
*Washington Park * City Park West*
303-282-5427

Date:

Patient Name: Date of Birth:

Address: Phone:

Authorization: I authorize the release of my optometry information as follows (select one)

To Name:	Or Send To:
Address:	Eyes of the World Optical
Fax: Phone:	Fax: 303484-3367 Phone: 303-282-5427
Email:	Email: staff@eyesofworld.com

Information to be release is limited to:

___ All Records ____ Spectacle Rx ____ Contact Lens Rx

Specific record years including or otherwise:_____

Notice: Eyes of the World Optical and other health organizations are required by law to keep your health information confidential. If you authorized your health information disclosure to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights:

- Authorization to release health information is voluntary. Treatment, payment, and eligibility for benefits may not be conditioned on signing this Authorization except for the following conditions: 1. To conduct research-related treatment, 2. To obtain information in connection with eligibility or enrollment in a health plan, 3. To determine an entities obligation to pay a claim, or 4. To create health information to provide to a third party.
- This authorization may be revoked at any time. The revocation must be in writing, signed you or patient representative, and delivered to Clinic Privacy Officer Channing A. Baird, O.D. The revocation will take effect once we receive this, except when others have already relied on it.
- You are entitled to a copy of this notice.
- Expiration of this notice shall be in 12 months past the signing date, unless specifically stated otherwise in this notice or by subsequent notice.

Signature:

_____ _____
Patient Name Date

_____ _____
Patient Signature Relationship if Representative