Meridian Family Eyecare
Dan C. Thieme, O.D.
1648 NW 2nd Street
Meridian, Idaho 83642
(208) 888-2200 fax (208) 888-7623

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____ Date of Birth_____
Address _____ Phone _____
City _____ State _____ Zip _____

I authorize the professional office of the physician named above to release and/or receive health information identifying me under the following terms and conditions:

1. Description of the information to be released(check all that apply):

☐Glasses Prescription ☐Contact Lens Prescription

☐Exam Records ☐Other:_____

2. Other office where the information is being requested from or to:

Name of Doctor/Office/Other:_____

Phone #_____ Fax #_____

3. The purpose(s) for the release (if the 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 for the release (if any):

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. If you wish to revoke your authorization, you must do so in writing and submit it to the address listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/ she wishes. State or federal law may determine this possibility.

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.

Dated_____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority_____