12422 Olive Blvd
Creve Coeur, MO 63141
Phone: 314-579-0909
Fax:(314)514-7413
OpticalExpressionsSTL@gmail.com

7718 Forsyth Blvd
Clayton, MO 63105
Phone: (314) 721-0909
Fax: (314) 721-7413
OpticalExpressionsClayton@gmail.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION
Dr. George J. Dowdy, OD, Privacy Official

Patient Name:
_____

Patient Address:
_____

Patient Phone#: _____ Patient
Email:_____

I authorize Optical Expressions to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions and HIV infection or AIDS) under the following conditions:

1. Detailed description of the information to be released:

_____

2. To whom the information will be released:

_____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization you may revoke it at any time by contacting us in writing, fax or email the Privacy Official noted in the Notice of Privacy Practices.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he or she wishes. We will not receive a financial benefit from disclosing this health information about you.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____
_____
Patient Signature Date

_____
_____
Representative Relationship to Patient
If you are signing as a personal representative of the patient, please indicate your relationship.