Optical Expressions	Optical Expressions
12422 Olive Blvd.	7718 Forsyth
Creve Coeur, MO 63141	Clayton, MO 63105
314.579.0909	314.721.0909
Fax 314.514.7413	Fax 314.721.7413

Patient Name ______________________ Patient social security #______________

Patient Address ____

Patient Phone # ____

Optical Expressions is authorized to collect health information identifying for (patients name)__________________________under the following terms and conditions:

1. **Detailed description of the information to be released: full exam history including eyeglass and contact lens information.**
2. **To whom the information will be released: Optical Expressions,LLC**
3. **Please fax the information.**
4. **Date you would like it sent: As Soon As Possible.**

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. You can also review your health information that we have on file, before deciding whether to sign this authorization. Our *Notice of Privacy Practices* explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office listed above, to initiate the process.

If you sign this authorization, you can revoke it later, except if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the office listed above.

When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/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. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED ABOVE.

____ _____________________

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship.

____ _____________________

Representative Relationship to Patient

Source of Authority: ____