Vision Therapy Center of Charlotte, LLC. Steven L. Haleo, O.D., F.C.O.V.D.

3686 Center Circle Fort Mill, SC 29715 803.802.7171 888.262.2020

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

The purpose for the release: To facilitate and better communicate the treatment of me or my child. This release shall expire one year from the date of signature unless otherwise noted

Patient Name:
DOB:
Street address:____
City, State, Zip: ______________________________________

I authorize the professional office of my optometrist, Dr. Steven L. Haleo 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
   ❑ Medical Diagnosis ❑ Treatment Dates, Plan and progress ❑ Other:_____________________
2. To whom may the information be released: ❑ School ❑ Tutor ❑ OT ❑ PT ❑ MD ❑ Speech Therapist
   ❑ Counselor ❑ Psychologist ❑ Other:___________________________

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 before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how to request access to your identifiable health information, and how we may respond. Basically, you simply need to send a written request to the Chief Compliance Officer listed at the top of this form to initiate the process.

If you sign this authorization, you can revoke it later. The exceptions to this are 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 Chief Compliance Officer 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 THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

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:
❑ Mother ❑ Father ❑ Legal Guardian ❑ Immediate Family Relative

Source of your authority to sign this form:
❑ Mother ❑ Father ❑ Legal Guardian ❑ Immediate Family Relative

Print name____

Signature:____Date:____________

©Copyright 2013 Steven L. Haleo, O.D., FCOVD