AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Dr. Shawna Heddinghaus, O.D.
Dr. Claud Snowden, O.D.

600 South 8th Street
Benld, IL 62009

Phone: 217.835.7724 Fax: 217.835.7611

Patient Name _____

Patient Address _____

Patient Phone Number _____

I authorize Fireside Eye Care, P.C. to release health and/or optical information to the follow individuals:

Name of party release is given to:	Relationship to Patient
_____	_____
_____	_____
_____	_____

Please check all that apply: ☐ Optical ☐ Medical ☐ Financial

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 writing to the attention of the Privacy Official at Fireside Eye Care, P.C. as noted in the *Notice of Privacy Practices*.

When your health information is disclosed under this authorization, the recipient you authorize has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

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

_____ _____
Patient Date

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

_____ _____
Representative Relationship to Patient