



Authorization for Release of Health Information

Please print clearly and complete every section before signing.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

1 Patient Information

Name		Date of Birth MM / DD / YYYY	
Address	City	State	Zip
Phone Number	Previous Name		

2 Who May Release My Records

Name of Health Care Provider / Plan / Other			
Address	City	State	Zip
Phone Number	Fax Number		

3 Who Should Receive My Records – check ONE

☐ Option A – Release to me I am the patient	Delivery: ☐ I will pick up ☐ Mail to my address above	
☐ Option B – Release to someone I name That person must show photo ID	Full name of person authorized to pick up my records	
☐ Option C – Send to another provider Or plan / organization – complete both lines	Name of health care provider, plan, or organization	
Send by (check one):	☐ MAIL – write full mailing address here	☐ FAX – fax number

4 Information to Be Released

Information to be released (check all that apply)

☐ Office Visit Records	☐ Diagnostic Test Results	☐ Operative Reports	☐ Other – describe
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Release records from	From (date)	to	To (date)	This authorization expires on	Expiration date MM / DD / YYYY
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If the time period is left blank, only the past two (2) years will be disclosed. Expiration may be no more than ONE year from the date signed; if left blank, this authorization expires one year from the date signed.

Purpose(s) of the disclosure (check all that apply)

☐ Continued Care	☐ Insurance	☐ Legal	☐ Disability Determination	☐ Second Opinion
☐ Personal	☐ Other – describe			

5 Your Rights With Respect to this Authorization

I understand that I have a right to inspect and receive a copy of the material to be disclosed. I understand that I may revoke this authorization at any time by sending a signed written request to VRA Vision, 5418 E Arrowhead Pkwy, Sioux Falls, SD 57110, or by fax to 605-318-5101. Revocation will not apply to information that has already been released in reliance on this authorization before VRA Vision receives my written request. My decision to sign this authorization will not affect my treatment. If this information is disclosed to an individual or entity that is not a health care provider or health plan, it may be subject to re-disclosure and no longer protected. A photocopy/facsimile or scanned copy of this form is valid as the original.

6 Signature

Form MUST be completed before signing.

Signature of Patient / Legal Representative	Date
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If signed by a person other than the patient, complete the following:

- Individual is: ☐ A Minor ☐ Legally incompetent or incapacitated ☐ Deceased
- Legal authority: ☐ Parent ☐ Legal guardian ☐ Next of kin/executor of deceased ☐ Activated POA for Health Care