



VisionFirst

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

STEP 1: Information about you: PLEASE PRINT

First and Last Name	Date of Birth
Phone Number	Cell Number
Street Address	
City, State and Zip	

STEP 2: Who has the records now?

Doctor or Office Name	
Phone Number	Fax Number
Street Address	
City, State and Zip	

STEP 3: To whom do you wish to release your records?

[] ALL RECORDS OR _____

[] Dates of Treatment: _____ to _____ OTHER _____

TO: Vision First Eye Center (place a check in the box next to the office you plan to use)

- Alabaster Fax 663-2015
- Lakeshore Fax 397-4190
- Trussville Fax 949-1400

STEP 4: Your Signature

This authorization is valid for one year and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required.

Patient's Signature Date

Witness Signature Date

STEP 5: Release of Sensitive Information:

I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.

Signature of Patient Date

STEP 6: Release of HIV Information:

IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING / TREATMENT RECORDS RELEASED, YOU MUST SIGN AND DATE ON THE LINE BELOW.

I AGREE TO THE RELEASE OF THIS INFORMATION

Signature of Patient Date