UC San Diego Student Health Service
Optometry Department (858) 534-2602

Authorization to Release Optometry Information

Today's date _________.

Patient Name: ______________________________________ **Former Name:** ______________________________

Address ____ **City:** ________________ **State:** _____ **Zip:** _______

Phone: (_____)____________________________ **Student ID #:** ____

Authorization

I authorize release of my optometry information as follows:

From: UC San Diego Student Health
Optometry Dept.
9500 Gilman Drive
La Jolla, CA 92093-0039

To: _________________________________
____
____
Phone: ________________________
Fax: ________________________

Limitations

The information to be released is limited to:

_____ All optometry records
_____ Spectacle Rx
_____ Other: ____________
_____ Visual Field
_____ Contact Les Rx

Purpose:

_____ Continuity of care
_____ At the request of the patient/patient representative
_____ Other: ____________________________________

UC San Diego Student Health Service and others such as physicians, hospitals and health plans are required by law to keep your optometry information confidential. If you have authorized the disclosure of your optometry information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment; 2) obtaining information in connection with eligibility or enrollment in a health plan; 3) determining an entity's obligation to pay a claim; or 4) creating health information to provide to a third party. I understand I am entitled to receive a copy of this authorization. Expirations: Unless otherwise revoked, this authorization expires _____________ (insert date), or 12 months after the date of signing this form if no date is indicated.

Signature

Patient Signature: ____ Date: _______ Time: ____ am/pm
(or legal representative)

Printed Name: _______________________________________ Relationship to Patient: __________________

Witness/Interpreter Signature: _________________________ Printed Name: _________________________