

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name (Print): _____

Address: _____

Date of Birth: _____

Date Records Requested: _____

I, patient undersigned below, authorize: **Peak View Optometry, PLLC** to release or obtain my medical information, receipts of payment or balance due, and/or other information considered under the HIPAA privacy law to be part of the Designated Record Set to or from the following contact or entity:

Name or

Agency: _____

Address: _____

Telephone # _____

Email: _____

Fax # _____

FORT CARSON

6110 Martinez St.
Fort Carson, Colorado 80913
P:719.368.2446
F:719.631.7014

PETERSON

1030 Stewart Ave, Bldg 2017
Peterson Colorado 80914
P:719.574.5252
F:719.631.7014

_____**EYEGLASS WORLD NORTH**

7190 N Academy Blvd
Colorado Springs, CO 80920
P: 719.653.8405
F: 719.598.0995

_____**EYEGLASS WORLD SOUTH**

353 N Academy Blvd
Colorado Springs, CO 80909
P: 719.574.3300
F: 719.574.3322

Peak View Optometry and the recipient designated above are released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient Signature _____

Date _____

Notice to Person or Agency receiving this information: This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.