

Authorization to Release Health/Personal Information

Name of Patient _____

Date of Birth _____

Phone _____ Cell # _____

Street Address _____

City, State, Zip _____

Email _____

Release Information to:

OLSON OPTICAL
302 1st Avenue S.
St. James, MN 56081
507-375-2020

Please send by fax or e-mail:

Fax: 888-217-3389
Email: info@olsonoptical.com

Health/Personal Information Requested:

Complete Records INCLUDING:

All Insurance information,
“Contact” Information this patient provided you to be included in their record. (Phone#'s etc.),
Glasses and/or Contact Lens Prescription Information.
****Past Four Years to Present Records Are Sufficient****

- By signing this form, I understand this office will act as my agent in obtaining payment from my insurance company; however, I further understand that I am ultimately responsible for my bill, including services not covered by Medicare or my Supplement.
 - I understand that in the course of providing services to me, this office creates, stores and receives information that identifies me. I authorize this office to use and disclose this identifying information as necessary for my treatment, payment and healthcare operations.
 - I authorize payment from any insurance company to be made directly to this office.
 - I acknowledge I have received a copy of this office's Notice of Privacy Practice policy.
 - I permit a copy of this authorization to be used in place of the original.
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This authorization shall be in effect until the information has been forwarded as requested.

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document.

Signature of Patient or Personal Representative

Date