

**HOPKINTON VISION CENTER**  
**Steven T Perryman, O.D.**  
10 Cedar Street  
Hopkinton MA 01748  
508.435.4711  
508.435.5053 fax  
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**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

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I authorize the professional office of Hopkinton Vision Center to release health information identifying me under the following terms and conditions:

1. In order to identify you to your insurance company to properly bill for your exam(s).
2. To communicate your health information to your PCP or other health care professionals if your eye exam information or history is helpful in their diagnosis/treatment plan.
3. To communicate with you through your contact information (Make phone calls/Write letters/Leave messages with family members)

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

If your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY INFORMATION AS DESCRIBED IN THIS FORM.

Dated \_\_\_\_\_ Patient signature \_\_\_\_\_

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient \_\_\_\_\_ Print Name \_\_\_\_\_