PATIENT RELEASE OF INFORMATION

Lions Eye Foundation of California-Nevada, Inc.
PO Box 7999, San Francisco, CA 94120
Phone (415) 600-3950 Fax (415) 600-3949

I. Explanation: Authorization for use or disclosure of my health information is required by state and federal law.

II. Authorization: This authorization applies to the health information for:

Patient: ________________________________ Date of birth: ______________

I, (patient or legal representative) ______________________________________

Authorize: ____
(Name and address of entity releasing records)

to release my complete eye exam, including visual acuity, external, slit lamps, muscles and fundus exams to Lions Eye Foundation and affiliate Lions Club.

I hereby authorize the Lions Eye Foundation of California-Nevada, Inc. to make any investigation concerning me and my dependents which is necessary to establish eligibility for assistance.

III. Expiration: The authorization shall become effectively immediately and shall remain in effect until (enter specific date of event):_________________________.

IV. Restrictions: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you, or unless the disclosure is permitted by law. This protection does not extend to recipients outside the state of California.

V. Your Rights:

- I understand that authorizing the release of this health information is voluntary. I may refuse to sign this authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address: Lions Eye Foundation, PO Box 7999, San Francisco, CA 94120. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization; the original of this document will be kept on file with Lions Eye Foundation. I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.

VI. Signature

Signature: ____________________________________ Date: _______________

Print Name: ____

Relationship to patient (if signed by someone other than patient): _______________

Witness (required if signed by someone other than patient): ____________________