DAKOTA VISION CENTER
Best care in sight.

- Dr. Vance Ankrum
- Dr. Rob Haeder
- Dr. Jeffrey Oakland
- Dr. Joel Quist
- Dr. Meghan Montreal
- Dr. Brett Lorenz

RELEASE OF IDENTIFYING HEALTH INFORMATION
AUTHORIZATION FORM

Patient Name: _____ DOB: _____

Patient Address: _____ Phone#_____

The Professional office named above is authorized to release health information identifying the above named patient under the following terms and conditions.

Information related to eye care services, prescription information, and medical information to be released to: _____
from: _____ for the purpose of continuing care for vision and eye health.
Expiration Date: _____ (if patient desires)

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you chose to not sign this authorization. You can review your health information that we have on file, before deciding to sign this authorization. Our Notice of Privacy Practices explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office contact person, listed above, to initiate the process.

If you sign this authorization, you can revoke it later, except 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 above.

(When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes).

We will not receive a financial benefit from disclosing this health information about you.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.

_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

_____ _____
Relationship to Patient Print Name

Source of Authority: _____

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