Adult Covered by Parental Insurance

(Young Adult, 18 -26 still under Parents Insurance)

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Southern Montana Optometric Center
210 First Ave
Laurel, MT 59044
(406) 628-8668
Ron Benner, Privacy Official

Patient Name _____

Patient Address _____

Patient Phone Number _____

I authorize Southern Montana Optometric Center to release health information identifying me under the following conditions:

Parents, Step Parents, Grandparents and/ or Guardians that have me covered under their insurance policies.

Expiration Date_____ **No Expirations ☐**

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices*.

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

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient **Date**

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative *Relationship to Patient*