MidWest Eye Center

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone (H): _____ Phone (W): _____

Address: _____ City/State/Zip: _____

Above listed patient authorizes the following healthcare facility to make record disclosure:

From Facility: _____ Facility Phone: _____

From Address: _____ Facility Fax: _____

City/State/Zip _____

Dates of Information Release Requirements:

☐ 2 years prior from last date seen

☐ Other Dates: _____

Expiration Date of Request:

☐ 6 months from date of request

☐ Other Dates: _____

The Purpose of Disclosure:

☐ Change of Insurance or Physician

☐ Continuation of Care (e.g. Long Term Care)

☐ Referral ☐ Marketing

☐ Family/Friends: _____

☐ Other: _____

Specific Information Requested:

_____

_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City/State/Zip: _____

Fax: _____ Phone: _____ ☐ **Please mail records.** ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been release in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Please Note: Copy fee may be charge for medical records $ _____ per page, with a minimum of $ _____ .

Signature of Authorized Representative: _____ **Date:** _____

Printed name of Authorized Representative: _____ **Relation to Patient:** _____

Address/Telephone of Authorized Representative: _____