st.paul eye clinic P.A.

Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ SS#: ____-____-____ MEDICAL RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize release of information from my medical record as indicated below.

FROM: NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

TO: NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

For Dates of Service

- ❑ All Eye Records (including operative and diagnostic testing) _____to_____
- ❑ Fundus Photographs Reports _____to_____
- ❑ Visual Fields _____to_____
- ❑ Fluorescein Angiograms _____to_____
- ❑ All Medical Records _____to_____

I specifically authorize the release of information relating to:
- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health (including psychotherapy notes)
- ❑ HIV related information (AIDS related testing)

X _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: ❑ Changing physicians ❑ Consultation/second opinion ❑ Continuing care
❑ Legal ❑ School ❑ Insurance ❑ Workers Compensation
❑ Other (please specify): _____

1. I understand that this authorization will expire on _____(Print the Date this Form Expires) days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by _____(Print Name of Provider) for the purpose of: _____
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   c. I have been informed that _____(Print Name of Provider) ❑ will / ❑ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with _____(Print the State Whose Laws Govern the Provider) statute, I will pay a fee of $ _____(Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT DATE

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____

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