AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:____ Date of Birth:_____/_____/_____

Address:____City/State/ZIP:_______________________________

Phone: ______________________________

I authorize the use or disclosure of my protected health information to:

❑ Plainfield Vision Care
15129 S IL Rt. 59 Unit B
Plainfield IL 60544
Ph: 815-609-3933
Fax: 815-609-3639
Secure email: info@visioncaregroup.net

❑ Naperville Vision Care
1783 S Washington St. Suite 111
Naperville IL 60565
Ph: 630-961-5255
Fax: 630-961-0335
Secure email: info@visioncaregroup.net

❑ Other Organization:____
Address:____City / State / Zip:____________________________
Ph:________________________Fax:___________________Secure email:______________________________

❑ Other Individual:________________________________Relationship to patient:________________________

The SPECIFIC type of information to be used or disclosed:

❑ Most recent eye examination record and or progress notes

❑ Most recent glasses and contact lens presctiptions

❑ Other:____

For the following date or range of dates of treatment:____________________________________

- I understand I have the right to revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any effect on disclosure of information by the providing organization before the notice of revocation was received.
- I understand this authorization will expire in 90 days or upon the following specified date_______________.
- I understand that information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.
- I understand I have the right to inspect/receive a copy of the information used / disclosed and receive a copy of this form.
- I understand I have the right to refuse to sign this authorization and that this form is not necessary for information disclosed for my treatment or to obtain payment related to my visit.

I HEREBY ACKNOWLEDGE I HAVE READ AND FULLY UNDERSTAND THE STATEMENTS AND CONSENT TO THE RELEASE OF RECORDS.

Patient Signature: ____Date: ______________________

Representative Signature (for minor, etc.)________________________________Date: ______________________

Relationship:____