Chicago Eye Care Center

Eye Care For The Entire Family
773-764-EYES (3937) fax: 773-764-3939
3104 W. Devon Ave Chicago, IL 60659
chicagoeyecarecenter@hotmail.com
www.chicagoeyecarecenter.com

Authorization for Release of Identifying Health Information:

Patient Name_____ Date of Birth_____
Purpose for the release of identifying health information is at the request of the Patient/Legal Guardian

Requesting Records From:

Doctor's office or Clinic_____Address_____
Phone #_____ Fax #_____

Sending Records To:

Doctor's office or Clinic_____Address_____
Phone #_____Fax #: _____

Description of the information to be released and Expiration date of release:

_____

I authorize the professional office of my optometrist named above to release health information identifying me including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services under the following terms and conditions: Detailed description of the information to be released: To whom may the information be released name(s) or class(es) of recipients: The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual) Expiration date or event relating to the individual or purpose for the release: It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is 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 listed at the top of this form. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility. For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature/Legal guardian_____Date_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____
Source of Authority