NorthwestEye
A Division of **Twin Cities Eye Consultants**

AUTHORIZATION FOR RELEASE OF INFORMATION

MD/OD reviewed/initials:

1 Patient:

Name		Age	
Address		Day Phone #	
City	State	Zip	Date of Birth
Previous name (s)	E-mail address (optional)		

2 Contact Information about how this form was filled out (Optional)

I give permission for the Organization(s) listed in section 3 permission to talk to:

Name

about how this form was completed, this person can be reached at:

Phone # | Email address (optional)

3 Health Care Facility/Provider:

WHO HAS THE INFORMATION YOU WOULD LIKE TO BE RELEASED?

Organization Name

Clinic Location

Providers Name

4 Requester: (If other than patient)

TO WHOM SHOULD THE INFORMATION BE SENT?

Organization Name		
And/or Persons Name		
Address		Fax Number
City	State	Zip
Information needed by (Date)		

5 Information to be released

Important: indicate only the information that you are authorizing to be released.

☐ All health information, including clinic notes, labs, special testing, contact lens information.

OR to only release specific portion of your health information, indicate the categories to be released:

☐ Consultation/Follow-Up Records
☐ Contact Lens Information
☐ X-Ray/Imaging
☐ Other Information or Instructions:
☐ Other Information or Instructions
☐ Special Tests

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information opt be released AND for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here. (Initials)_____

7 Reason(s) for Releasing Information

☐ Patient's Request
☐ Continuation of Medical Care
☐ Relocation
☐ Insurance Application
☐ Other (Specify)
☐ Legal
☐ Disability
☐ Insurance Change
☐ Consult/Second Opinion

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I understand that by signing this form, I am requesting that the health information specified in section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(is) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date:_____ Or Specific event:

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Patient's Signature_____ Date:_____

OR legally authorized representative's Signature _____

Representative's relationship to patient (parent, guardian, etc.)_____ Date:_____

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