NorthwestEye
Be Eye Wise

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient:	Name			DOB
	Address			Preferred #
	City	State	Zip	Email
Release Information From:	Facility / Provider			
	Address			
	City		State	Zip
	Phone #	Fax #	Email	
Release information To:	Facility / Provider / Name			
	Address			
	City		State	Zip
	Phone #	Fax #	Email	

Information to be Released

☐ Medical records from the following dates: From _____ To: _____

☐ All Medical Records

☐ Other(please specify) _____

REASON FOR RELEASE

☐ Continuation of Medicare Care
☐ Insurance
☐ Attorney
☐ Request Personal
☐ Other _____

Revocation:

- I understand this authorization will be in effect for 12 months unless stated otherwise or canceled by me in writing. The cancellation will take effect when the request is received.
  Please note time frame of authorization if less than 12 months: _____
- I understand when the health information requested is sent to a third party, the information could be re-disclosed by the third party, and may no longer be protected by federal or state privacy laws.

Authorization:

I authorize Northwest Eye to release the information to the party noted above.

Name of Patient or Authorized Representative _____

Signature of Patient or Authorized Representative _____ Date _____

Fax (952) 473-4218 or Email forms to: roi@nweyeclinic.com

Questions regarding Release of Information, please call (763) 383-4184.
For appointments call (763) 416-7600.

www.nweyeclinic.com