Primary EyeCare

Primary EyeCare-Delano
1045 Crossing Dr., Suite 200
Delano, MN 55328
763-777-9393
Fax: 763-777-9358

Primary EyeCare-Hutchinson
1059 Hwy 15 S.
Hutchinson, MN 55350
320-587-4744
Fax: 320-587-9168

Primary Eyecare-Litchfield
520 Hwy 12 E., Suite 106
Litchfield, MN 55355
320-693-9333
Fax: 320-593-0520

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
Please print all information. Form must be signed and dated.

Patient Name: _____

Date of Birth: _____ Phone #_____

Records to be released FROM: _____

Address: _____

Phone # _____ Fax #_____

Records to be released TO: _____

Address: _____

Phone # _____ Fax #_____

Description of information to be disclosed- I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above.

___ **All Clinical Records**
___ **All Clinical Records Only Related to:** _____
___ **Visual Fields**
___ **Fundus Photography and/or Retinal Imaging**

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

___ Patient Request ___ Other (please specify)_____

* This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____

* You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

* The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

* We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the the Privacy Rule, and will no longer be the responsibility of the practice.

_____ Date: _____
Patient or Legal Representative Signature

_____
If signed by Legal Representative, Print Name and Relationship to Patient Signature of Witness