Eye Physicians & Surgeons, LLP
2629 Northgate Drive
Iowa City, IA 52245
Ph: 319.338.3623
Fax: 319.338.7289

CONSENT TO RELEASE OF INFORMATION

Please PRINT (except signatures) and provide complete answers (and addresses) in each section.

Patients' Legal Name: _____ Date of Birth: _____/_____/_____

__ A.Cohen, MD __C.Olson,OD __ S. O'Neill, OD __ L. Strnad, MD __Chris Watts, MD __L. Wendel, MD

I, the undersigned, hereby authorize Eye Physicians and Surgeons, LLP to **RELEASE** / **OBTAIN** medical information concerning the above named patient to / from:

_____/_____/_____
Name of Person, Doctor, or Institution who will receive / release the information Phone FAX

_____
Complete Mailing Address City State Zip

Check the information to be disclosed: _____ **Minimum necessary information** **OR** specify as follows:
__ Medication List __Allergy List __Problem List __History and Physical (specify date) _____
__ Office chart notes (dates) _____ __Lab results __X-ray and imaging reports(specify dates)_____
__Test results (e.g. EKG, etc) specify type and date_____
__Consultation reports (specify doctor & dates) _____
Other: _____

Please specify reason for release of information: Moving out of area ___ 2nd Opinion ___ Personal file ___ Legal ___
Other medical care ___ Transferring care ___ Other _____ **Date records are needed by**: _____

This authorization will automatically expire one year from the date of signature, except as specified _____
Specify # of days or months

- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by recipient and no longer be protected by HIPAA.
- I understand that I may revoke this consent at any time by sending a written notice to: "Medical Records" at Eye Physicians and Surgeons, LLP.
- I understand that any release which was made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I also understand that once information is disclosed, it may no longer be protected by federal privacy regulations.
- I understand that I may review the disclosed information by contacting: "Medical Records" at Eye Physicians and Surgeons, LLP
- Eye Physicians does not require completion of this form as a condition of treatment. However, when the requested treatment is solely for the purpose of creating a medical report for a 3rd party, if authorization to release the information to that 3rd party is not provided, it may result in the cancellation of those services.

*_____ _____
SIGNATURE of Patient OR Legal Guardian **DATE**

_____
Address City State Zip

_____ _____
Relationship, if Not the Patient Witness

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OF FEDERAL LAW
I specifically authorize the release of data and information relating to: (check appropriate box)
_ 1. Substance Abuse (alcohol/drug abuse) _ 2. Mental Health (includes psychological testing) _ 3. HIV-Related Information (AIDS related testing)

*_____ _____
Signature of Patient or Legal Guardian Date
* In order for this information to be released, you must sign here AND above, and check the appropriate box(es).

Records Prepared by: _____ Date: ___/___/___ Records Delivered by: ___Mail ___ Fax ___ In person ___ Other