1719 Tower Dr. W Ste 100
Stillwater, MN 55082

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(ALL SECTIONS OF THIS RELEASE MUST BE COMPLETED OR THE RELEASE MAY NOT BE PROCESSED)

PATIENT NAME: _____ **BIRTH DATE:** ___/___/____

MAIDEN OR OTHER NAME (S)_____ **PHONE NUMBER** _____-_____-_____

Records Needed by: ☐ **I have an appointment on** _____ ☐ **I will pick-up on** _____

Patient/Patient Representative requests only:

☐ Check this box if you do not want your records sent via electronic means (e.g. NextMD or on a CD/DVD).
☐ Check this box if you are requesting your entire medical record

I authorize Associated Eye Care . to use or disclose (as applicable) the following information (check all that apply):

☐ **All Eye Records**	☐ **Special Tests**	☐ **Contact Lens Records**
☐ **Operative/Procedure Reports**	☐ **Pathology Reports**	☐ **Glasses Records**
☐ **Visual Fields**	☐ **Billing Statement**	☐ **Procedure Images**

☐ **Other (specify)** _____

Please indicate date(s) of treatment: _____

Health facility, doctor, person(s) RELEASING Protected Health Information:

☐ **FROM or** ☐ **TO**

Associated Eye Care.
Attention: HIM
1719 Tower Dr. West, Suite 100
Stillwater, MN 55082
651-275-3032 (fax)/651-275-3000 opt 5 (phone)

The information described above may be DISCLOSED/RELEASED to the following recipients:

☐ **FROM or** ☐ **TO**

_____
Name

_____
Address – or fax number

_____
City, State **Zip**

Reason for the use or disclosure (as applicable) is for the purpose of:

☐ **Continuing Medical Care** ☐ **Insurance** ☐ **Legal** ☐ **SSI Disability Appeal**
☐ **Research** ☐ **At the Request of the Patient** ☐ **Other Specify** _____

- **I understand that Associated Eye Care will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form, except in the following situations:**
  - **If the medical information to be disclosed will result from treatment for research purposes, Associated Eye Care will not provide the treatment if I am unwilling to sign this authorization form.**
  - **If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Associated Eye Care. will not provide the treatment if I am unwilling to sign this authorization form.**
- **I understand that I may revoke this authorization by sending a written request for revocation to Associated Eye Care Privacy Officer. If I revoke this authorization, Associated Eye Care. will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when Associated Eye Care. discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.**
- **I understand that there may be a fee associated with the release of my medical information.**
- **I understand that this authorization will expire 12 months from the date signed unless I indicate otherwise here** _____

_____ _____ _____
Signature of Patient or Authorized Representative **Date (DD/MM/YYYY)** **Relationship to Patient (e.g. Self, POA)**

Reason Patient is Unable to Sign Release: ☐ **Minor** ☐ **Deceased** ☐ **Other:** _____
(Please specify and provide legal paper as needed)