AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name ____ Date of Birth ____________________

Current Address ____

City ____________________ State ________ Zip Code _________ Previous Name ____________________

THIS WILL AUTHORIZE:	**TO RELEASE TO:**
________________________________	________________________________
Name/Heathcare Provider/Other	Name/Doctor/Other
________________________________	________________________________
Address	Address
________________________________	________________________________
City, State, Zip Code	City, State, Zip Code
________________________________	________________________________
Fax Number	Fax Number

<u>TYPE OF DISCLOSURE:</u> __________ **COPY** __________ **VERBAL**

Information to be disclosed/released:

( ) **Specify Date(s) or Date Range: ____

( ) All Clinic Exams*	( ) Complete Copy of All Records*	( ) Operative Reports	( ) Pathology Reports
( ) Visual Fields	( ) OCT	( ) Photos	( ) Audiograms
( ) Lab Reports	( ) Diagnostic Imaging Reports	( ) Other ______________________________	

***This does not include records received from other facilities unless you specify on the "OTHER" line located above. **Records will be limited to the last 2 years of information if you do not specify above**

<u>PURPOSE OF RELEASE:</u> (check all that apply)

( ) Transferring Medical Care	( ) 2nd Opinion	( ) Change of Insurance	( ) For Insurance Company
( ) Patient Dissatisfaction	( ) Worker's Compensation	( ) Moving	( ) Other ____________________

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to:

YES	**NO**	
______	______	1. Substance abuse (alcohol/drug abuse)
______	______	2. Mental health/ depression (included psychological testing)
______	______	3. HIV-related information (AIDS related testing)
______	______	4. Sexually transmitted infection information

<u>Acknowledgements:</u>

This authorization will expire on______________________, 20_____ or 1 year from my signature date below. I understand I may revoke this consent at anytime by notifying the above provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I acknowledge that recipients of this information may possibly re-release this information without proper authorization and once information is disclosed, it may no longer be protected by federal privacy regulations. Wolfe Clinic does not require completion of this form as a condition for evaluation and treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in cancellation of the services.

______________________________________ ________________ __________________________

Signature of patient or legal representative ***Date*** ***Daytime phone #***

____________________________ **A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased and if such, the authorized representative is required to submit a copy of legal documentation supporting his/her authority to act on a patient's behalf.**

Relationship, if not patient

FOR OFFICE USE ONLY: _____Mailed Records ____ Faxed Records on (date) _______________ By __________________

____ Pt to pick up on ___________________ in ___________________ office Completed ______________