WOLFE EYE CLINIC

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*Family Vision Center*

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____ Date of Birth _____

Current Address _____ Phone # _____

City _____ State _____ Zip Code _____ Previous Name _____

**THIS WILL AUTHORIZE:**

_____
Name/Doctor/Other

_____
Address

_____
City, State, Zip Code

_____
Fax Number/email address

**TO RELEASE TO:**

_____
Name/Doctor/Other

_____
Address

_____
City, State, Zip Code

_____
Fax Number/e-mail address

**Upcoming Appointment Date: _____**

**TYPE OF DISCLOSURE:** **_____ 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**

**PURPOSE OF RELEASE:** (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 |

**Acknowledgements:**

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*** ***Printed Name of signee, if not patient*** ***Date***

_____

***Relationship, if not patient***

**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.**