

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

The information that you are requesting may be available through your patient portal at [www.advancedeyecaresc.com](http://www.advancedeyecaresc.com)

**Section 1: Patient Information (please print and complete all fields)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Section 2: Information Requested (please check appropriate boxes)**

- Progress Notes       Testing Images       Labs       Operative Reports       Billing

For the following dates of treatment: \_\_\_\_\_

(example: specific date: 01/25/2013; range of dates: January to July 2014)

**NOTICE ABOUT SENSITIVE INFORMATION, IN ACCORDANCE WITH 45 CFR § 171.204(A)(2):** Advanced Eye Care, SC’s electronic medical record system cannot segment (1) Mental Health, (2) HIV/AIDS/STD, (3) Genetic Testing, or (4) Drug/Alcohol Abuse (collectively, “sensitive information”) from other information in your medical records. Therefore, this sensitive information will be released to the individual/organization named in section 3 upon you signing this form.

**Section 3: I authorize Advanced Eye Care, SC to release the above patient records to:**

Name of Individual/Organization: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Section 4: Method of Delivery**

- Fax       US Mail       In-person pickup (will be released to patient only)

**Section 5: Purpose of Disclosure**

- Continuation of Care       Personal       Transfer of Care (Permanently Leaving)
- Insurance       Legal       Other: \_\_\_\_\_

**Section 6: Signature(s)**

I understand I have the right to revoke this authorization in writing at any time by sending revocation to Advanced Eye Care, SC at 1870 Silver Cross Blvd Ste 110 New Lenox, IL 60451. This revocation will not apply if AEC has already acted in reliance on the authorization. I understand this authorization will expire in 90 days or on this specified date \_\_\_\_\_ or event \_\_\_\_\_. I understand information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by law. I understand I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form. I understand that disclosure will include Mental Health, AIDS/HIV/STD, Genetic Testing, and Drug/Alcohol Abuse information (see section 2). I understand I have the right to refuse to sign this authorization, and DMG does not condition treatment on this authorization, except disclosure necessary for payment of claims or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (ie: school vision exams, DMV licenses exams).

I hereby acknowledge I have read and fully understand the statements and consent to the release of records.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_

Representative Signature (for minors, persons under guardianship, etc.) \_\_\_\_\_

Representative relationship: \_\_\_\_\_ Date: \_\_\_\_\_

RETURN VIA FAX TO: ADVANCED EYE CARE, SC 815-485-3034