AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The information that you are requesting may be available through your patient portal at 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**