MILWAUKEE EYE CARE
EST. 1933

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION AND MEDICAL RECORD RELEASE FORM

Please complete all items on the form and if you have any questions about this form, please contact our Medical Records Department at 414-271-2020.

**PATIENT NAME**: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE NUMBER: _____ LAST 4 DIGITS OF PATIENTS SOCIAL SECURITY # _____

**I authorize the information to be disclosed by:** ☐ Milwaukee Eye Care Associates, S.C. ***OR*** ☐ Other*

*Agency/Facility/Person to release the information: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Fax Number: _____ Appointment Date (if applicable): _____

**I authorize the information to be disclosed to:**

☐ Milwaukee Eye Care Associates, S.C – 1684 N. Prospect Avenue, Milwaukee, WI 53202 or Fax: (414) 271-4657

☐ Agency/Facility/Person to receive the information: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Fax Number: _____ Appointment Date (if applicable): _____

**Purpose of Disclosure:** ☐ Further Medical Care: Relocating ☐ Yes ☐ No ☐ Application for Insurance
☐ Payment of Insurance Claim ☐ Disability Determination ☐ Legal Investigation ☐ Forms Completion
☐ Personal Reasons/Other: _____

**Information to Be Disclosed (check all that apply):** **DATE OF SERVICE:** _____

| | | | |
|---|---|---|---|
| ☐ All Records | ☐ ER Records | ☐ Pathology Report | ☐ Progress Notes |
| ☐ History and Physical | ☐ Outpatient Visit | ☐ X-ray Imaging | ☐ Consultation |
| ☐ Billing Statements | ☐ Operative Report(s) | ☐ X-ray Imaging Report | ☐ Lab Report(s) |
| ☐ Discharge Summary | ☐ EKG/Echo | ☐ Other: _____ | |

***The information to be released via ☐ US mail ☐ Fax ☐ Pick Up – Date:** _____

This authorization is effective until _____ (if no date is entered the authorization will be valid for 1 year from date of signature) and includes records that were created or existed on or before the date of this authorization was signed.

☐ This includes records that are created after the date this authorization is signed, up until the expiration date._____ (Initials)

***The following information is important for you to read***:

- I understand that the information to be disclosed may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STD's, HIV test results, developmental disabilities, and genetic testing results.
- I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released.
- **I understand that I have a right to inspect and/or receive a copy of the health information to be released and I may be charged a fee for any copies of the medical records that I receive.**
- I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described in this form are not health plans, covered health care providers or health care clearinghouses subject to the federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health law.
- I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment.
- A photocopy of this authorization shall be considered as valid as the original.

_____

Signature of Patient or Legal Representative Date Time

If signed by someone other than the patient, state legal authority:

☐ Legal guardian of the patient (proof of guardianship required)
☐ Parent of the above-named minor child and I represent that I have not been denied periods of physical placement with my child by a court.
☐ The legal representative of a deceased patient (proof required)
☐ The agent under an activated Healthcare Power of Attorney (proof and statement of incapacity required)
☐ Other (specify): _____

**Internal Use: Information released by:**
Fax Number: _____ US Mail _____ fee: $_____ Pick Up_____
Completed by: _____ Date: _____ Time: _____