PATRICIA L. DAVIS, M.D.
PEDIATRIC & NEURO-
OPHTHALMOLOGY

KATHY ANDERSON, M.D.
PEDIATRIC OPHTHALMOLOGY

MARGARET SLOWIK, O.D.
FELLOW AMERICIAN
ACADEMY OF OPTOMETRY

Authorization for Release of Patient Health Information

Patient Information:

Patient Name _____ Patient Date of Birth _____

Address _____

City / State / ZIP _____

Telephone # _____

I hereby authorize the protected health information regarding the above-named person to be exchanged between:

From/To:	**From/To:**
Person / Institution _____	Person / Institution _____
Address _____	Address _____
City _____	City _____
State / ZIP _____	State / ZIP _____
Telephone # _____	Telephone # _____

I authorize the release of information covering the period(s) of healthcare from:

Date(s) _____ To date(s) _____

The type of information to be used or disclosed is as follows:

☐Abstract (documents summarizing health history)	☐History and Physical Examination	☐Discharge Summary
☐Consultation Reports	☐Operative Reports	☐Diagnostic Reports
☐Progress Notes	☐X-Ray Images	☐**Verbal only** (*please specify*)
☐Other (*please specify*) _____		

The following highly confidential items must be checked off to be included in the use or disclosure of other health information:

☐Genetic testing information and/or records ☐Information about child abuse and neglect

Patient 12 or over MUST AUTHORIZE this release by checking the box below and signing:

☐HIV/AIDS related health information and/or records
☐Behavioral or mental health information and/or records *(Release must be witnessed, Patient 12 or over must authorize)*
☐Information about sexually transmitted disease
☐Pregnancy
☐Birth control
☐Drug/alcohol diagnosis, treatment, and/or referral information

This information for which I'm authorizing disclosure will be used for the following purpose:

☐My personal use **(there is a fee for personal use copies)**
☐Sharing with other health care providers **(no charge if sent directly to the provider – address must be provided as recipient above)**
☐Other (please specify) _____

3100 OGDEN AVE. • LISLE, IL 60532
PHONE: (630) 245-0989 • FAX: (630) 527-0125

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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PATIENT NAME _____

PATIENT DATE OF BIRTH _____

Unless revoked, this authorization will expire 30 days from the date of signature on the authorization or from the date noted above.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in the Authorization, in which case Progressive Eye care may refuse to treat me if I do not sign this Authorization.

I understand that once Progressive Eye care discloses my health information to the recipient, Progressive Eye care cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Progressive Eye Care management office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that Progressive Eye Care may, directly or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information.,

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentially Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act information may not be re-disclosed unless the person who authored this disclosure specifically authorizes the re-disclosure.

I understand that I have the right to inspect and obtain a copy of any information about mental health, drug and alcohol, or developmental disability services that is disclosed pursuant to this Authorization.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Progressive Eye Care to use or disclose my health information in the manner described above.

Printed Name of Patient or Legal Guardian _____

Relationship _____

Signature of Patient or Legal Guardian _____

Date _____

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