Children's Eye Clinic, PC
6000 University Avenue, Suite 210
West Des Moines, Iowa 50266
Phone: 515-222-1180 Fax: 515-222-9635

Authorization for Release of Identifying Health Information

Patient's Name_____ Previous Name_____

Address _____ Date of Birth_____

_____ Account Number_____

This will authorize: **To release to:**

_____ _____

_____ _____

_____ _____

Phone Number_____ Phone Number_____

Fax Number_____ Fax Number_____

Description of information to be released: (office notes, operative reports etc.)_____

_____

Purpose of release:

_____Transferring Medical Care _____Moving
_____Second Opinion _____For Personal Records
_____To Update Another Doctor _____Dissatisfaction with Care
_____Other _____

Specific Authorization For Release of Information Protected by State or Federal Law:

Yes	No	
_____	_____	Substance Abuse (alcohol/drug abuse)
_____	_____	Mental Health/Depression (includes psychological testing)
_____	_____	HIV related information (AIDS related testing)

This authorization will automatically expire one year from date of signature or until_____.
This consent may be revoked at any time by notifying the above named 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.

Restrictions:

This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

_____ _____ _____
Signature of patient or legal guardian Relationship, if not patient Date

_____ _____
Daytime phone number Cell phone number