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:
____
____
____
Phone Number_________________________________
Fax Number___________________________________

To release to:
____
____
____
Phone Number_________________________________
Fax Number___________________________________

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

____

Purpose of release:

_______Transferring Medical Care
_______Second Opinion
_______To Update Another Doctor
_______Other ____
_______Moving
_______For Personal Records
_______Dissatisfaction with Care

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 **release will expire one year from date of signature** unless otherwise noted:_____________________.
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.

If the patient is 18 years or older, they will need to sign this release.

____________________________________ ____________________________ ______________
Print name Relationship, if not patient Date

____________________________________ ____________________________
Signature Primary phone number