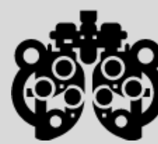

MILWAUKEE
EYE CARE
EST. 1933

AUTHORIZATION FOR RELEASE OF CONFIDENTAL INFORMATION

NAME OF PATIENT:
DATE OF BIRTH:

I authorize the information to be released

From
☐Milwaukee Eye Care
☐Facility Name:
Facility Phone
Facility Fax

To
☐Milwaukee Eye Care
☐Facility Name:
Facility Phone
Facility Fax

Please release the following:
☐Entire Medical Record
☐Other:
☐Records Covering services from dates ____________________ to ____________________
☐All records between these dates
☐Consultation Reports
☐Imaging Reports
☐Other:

The purpose of this disclosure is:
☐Coordination of Care
☐Legal Case
☐Requested by patient, or guardian/parent
☐Other

1. I understand that I may revoke this authorization at any time by submitting a written request unless the records have already been released.
2. I understand that the party receiving my information might not be subject to HIPAA and might be allowed to disclose this information
3. The facility releasing the records does not require that I sign this authorization in order to receive services.

Expiration Date:
☐90 days from date signed
☐Other date:

Approved By: **Date:**

If signed by someone other than the patient
Print Name:
Authority to sign:
☐Parent or Guardian
☐Appointed by patient as HIPAA Personal Representative
☐Other:

For staff use (complete the following steps and indicate by a check)
☐Copy of signed authorization given to Patient / Parent / Guardian
☐Copy of records released given to Patient / Parent / Guardian (if requested)
☐Revocation received on __________ and acted upon

MILWAUKEE EYE CARE
1684 N. Prospect Ave. Milwaukee WI 53202
Phone: 414-271-2020 Fax: 414-261-0210