MINNESOTA EYE CONSULTANTS MINNESOTA EYE LASER & SURGERY CENTERS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ **Date of Birth:** _____ **Phone:** _____

Request release of information FROM:

Minnesota Eye Consultants Medical Records
9801 Dupont Ave S
Bloomington, MN 55431
Fax: 952-567-6156

Request release of information TO:
(If Release is to self, state "Self")

_____ (Physician, Facility)
_____ (Street Address)
_____ (City/State/Zip code)
Phone: _____Fax: _____

For release of medical record information for additional minor children (ages 17 and under), list below:
Name(s): _____ Date(s) of Birth: _____

Please select which records you are requesting *(check all that apply)* ☐**Clinic Records** ☐**Surgery Records**

Please release the following information *(check all that apply)*
- ☐ Any and all medical records (past year)
- ☐ Medical records from the following dates:
  From: _____ *To:* _____
- ☐ Physician Notes
- ☐ Operative Reports
- ☐ X-Ray/Diagnostic Reports
- ☐ Laboratory Reports
- ☐ Medical records relating to a specific injury
  Specify Injury: _____ *Date of injury:* _____

Reason for Release *(check all that apply)*
- ☐ Continuing medical/surgical care
- ☐ Insurance Company
- ☐ Attorney Request
- ☐ Personal
- ☐ Other *(please specify)*
  _____

This authorization will remain in effect no longer than one year from the date of signature or until the following date or event: _____

All information regarding chemical dependency, mental health, alcohol abuse, HIV, or sickle cell anemia will be released unless you restrict here by checking the appropriate area and initialing your restrictive action. Please exclude:
☐Chemical Dependency ☐Mental Health ☐Alcohol Abuse ☐HIV ☐Sickle Cell Anemia PLEASE INITIAL: _____

I understand this authorization may be revoked by me, in writing, at any time, but would not apply to any information already released in good faith. A request for revocation or questions about disclosures may be sent to Minnesota Eye Consultant's Privacy Officer. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure at which time the information may not be protected by federal privacy rules. I understand the authorized disclosure of my medical information is voluntary. I can refuse to sign this authorization and still be assured treatment, payment, enrollment, or eligibility of benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in 4.5 CFR 164.524.

_____ _____
Name of Patient or Authorized Representative **Date**

_____
Signature of Patient or Authorized Representative