Apple Valley Eye Care

Authorization to release and disclose patient information

Patient Information	**Name** ________ **Date of Birth** ________ **Address** ________ **Best Phone** ________ **City** ________ **State** ________ **Zip Code** ________
Clinic / Health Care Provider (who has the information you want released?)	**Name** ________ **Phone** ________ **Address** ________ **Fax** ________ **City** ________ **State** ________ **Zip Code** ________
Information to be Released	☐ Clinic (office visit, refractive eye exams, specialty testing) ☐ Billing Records
Release Instructions (where you want the records sent to)	**Name** Apple Valley Eye Care **Phone** 952-432-0680 **Address** 7789 147th Street West **Fax** 952-432-8823 **City** Apple Valley **State** MN **Zip Code** 55124 **Date information is needed:** ________ (please allow 72 hours processing)
Purpose for Release (check applicable)	☐ Continuing Care ☐ Personal use or review ☐ Litigation / legal ☐ Transfer of Care ☐ Insurance application ☐ Insurance application ☐ Social Security appeal ☐ Social Security disability determination ☐ Other

* Apple Valley Eye Care will not restrict my treatment if I choose not to sign this authorization
* This authorization may be canceled in writing at any time. A cancellation will not change the releases that happen before the cancellation.
* A photocopy or fax of this authorization will be treated in the same way as the original.
* Apple Valley Eye Care cannot prevent redisclosure of your information by the person or organization who receives your records. In some cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.
* This authorization lasts for one year after the date it is signed unless you enter a different expiration date here: ________
* By signing this form, you release Apple Valley Eye Care from any and all liability from a redisclosure by the recipient.
* Your signature indicates that you have read and understand this form, and authorize release of your information as described above

________	________	________
Patient / Legal Guardian Signature	Date	Authority to act on behalf of patient (attach document)