

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