Premier Vision Clinic
12695 University Ave Suite 170
Clive, IA 50325
P 515-512-1444
F 515-512-1440

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name: ______________________________ Birthdate: ________________
Previous Name: (if applicable) ____
Address: ____
City: ___________________________State: __________ Zip: _______________

This will authorize:
Doctor's Name and Facility: ____
Address: ____
City: ___________________________State: __________ Zip: _______________

To release the information listed below to Dr. Jennifer DenHartog, OD:

___ Medical and Exam information
___ Glasses Prescription
___ Contact Lens Prescription

THIS WILL AUTHORIZE FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW. I SPECIFICALLY AUTHORIZE THE RELEASE OF DATA AND INFORMATION RELATING TO:

Circle One:

Yes	or	No	Substance abuse (alcohol/drug use)
Yes	or	No	Mental Health/Depression (includes psychological testing)
Yes	or	No	HIV related information/AIDS testing

This authorization will automatically expire one year from the date of signature or until ____________. I understand that I may revoke this consent at any time by notifying the above named provider of information. Any release of information made prior to my revocation is in compliance with this authorization and 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.

Signature of Patient or legal guardian: ______________________________Date_________

Relationship if not patient: ____

For office use only : Faxed to: ___________ By: ______________ Date: __________