Authorization to Release Medical Information

Name (First, Last): _____ **Date of Birth:** _____
Address: _____ **Telephone**: _____
City/State/Zip:_____,_____,_____ **Guardian Name**: _____

I authorize:

❑ **Wallerich Eye Care – St. Paul (Midway)**
1300 University Ave W
Saint Paul, MN 55104
T: (612) 643-3525
F: (612) 299-1452
Email: OM@WallerichEyeCare.com

❑ **Wallerich Eye Care – Eden Prairie**
8225 Flying Cloud Drive
Eden Prairie, MN 55344
T: (612) 699-8525
F: (612) 299-1452
Email: OM@WallerichEyeCare.com

☐ To release information to:

☐ To obtain information from:

_____

Name **Organization**

_____

Address **City** **State** **Zip**

_____

Fax Number **Phone Number**

I hereby authorize the release & communication of information both written and verbal between this office (above) and the party named above in all matters concerning the history and any examination, treatment and/or care of the patient.

Requested Records (select all that apply): ☐ Eye Exam Records ☐ School Records/IEP report(s)
☐ Imaging (MRI/CT/X-Ray) ☐ Lab Testing
☐ All records ☐ Other: _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will remain active unless an expiration date has been designated or by written revocation (via letter, email) by the patient or guardian of the patient. A copy of this authorization may be used with the same effectiveness as an original.

Indefinite (please check): ☐ ***Expiration Date:*** _____

HIPAA Required Statements:

- I understand that non-research treatment may not be conditioned upon signing this release.
- I understand that the information provided under this release may be subject to redisclosure by the recipient under circumstances no longer protected by HIPAA privacy rules.
- I understand that I may revoke this release at any time***, except to the extent that action has already been taken to comply with it***. To revoke this authorization, I must provide written notice to the health plan, doctor, or health care provider (*email provided above or certified letter*) named in this release and written notice to the organization or entity to whom I have authorized the release of information.

Patient Signature: _____ Date: _____

Guardian authorized to sign for patient: _____ Date: _____

Relationship to Patient: _____