The difference is in sight.

Professional Solutions for Cataracts, Glaucoma & Cornea

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

____ _____________________________________
Patient Name Patient Date of Birth

____ _____________________________________
Patient Street Address City, State, ZIP Code

☐ I wish to release records from Tower Clock Eye Center to:

-OR-

☐ I wish to request records released to Tower Clock Eye Center from:

Clinic/Doctor: ____

Address: ____

City, State, Zip: ____

Telephone: ___________________________ Fax: ____________________________

Information to be released:

☐ Medical history, examination, reports ☐ Prescriptions ☐ Hospital Reports
☐ Surgical Reports ☐ Consultations
☐ Other: ____

Purpose for Need of Disclosure:

☐ Transfer of Care ☐ Continuation of Care ☐ Insurance
☐ Personal ☐ Legal

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal standards and my health information might be re-disclosed without my authorization.

I understand I have a right to:

- Receive a copy of this authorization.
- Refuse to sign this authorization and that treatment, payment enrollment in a health plan or eligibility benefits may not be contingent on my signing this authorization.
- Revoke this authorization, except to the extent that the person(s) and organization(s) listed above made in reference to this authorization.

This authorization will remain in effect until (one year of signed date) __________________ or event: ______________________.

_____________________________________ _________________________ ____________________________
Signature of patient (or legal representative) Relationship to patient Date

This release is executed in conformity with Wisconsin Stats §§146.81-83, 252.15

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