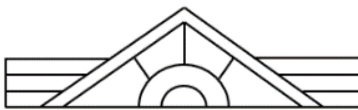

PRAIRIE
Eye Center, LTD
2020 West Iles Ave.
Springfield, IL 62704
217-698-3030

Authorization to Release Verbal Medical Information to Persons Involved in my Care:

Name of Patient (Please print): ____ DOB: ________________________

Daytime Phone: ____ Clinic Record #: __________________________

I hereby give the Prairie Eye Center, Ltd. my permission to release my medical information to the individuals specified below, upon their request. Methods of release may include verbal discussions or updates about my treatment(s), medication(s), or condition(s) as requested. The purpose for these disclosures is to enable the persons below to assist me in maintaining my health, and to participate in my medical care.

Name	Relationship to patient	Daytime Phone #

The patient or the patient's representative must read and initial the following statements:

1. I understand that I may see and receive a copy of the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initial: _____________

2. The information disclosed may include matters regarding mental health, developmental disability, alcohol or drug abuse, infectious diseases including HIV, elective cosmetic procedures, and medical correspondence. I you do not wish such information to be released, do not complete this form. Inform the Receptionist of your decision, to verify and revoke any prior authorizations. Initial: ___________

3. I understand that I may revoke this authorization at any time by notifying Prairie Eye Center in writing, but the revocation will not affect any actions which they have taken prior to the receipt of revocation. Without express written revocation directed to the Prairie Eye Center, I understand that this authorization will not expire during the remainder of my treatment period with Prairie Eye Center, and until such time as I present Prairie Eye Center with a revocation of authorization or complete a new authorization form. Initial: __________

4. I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand and acknowledge that the confidential healthcare information disclosed and used pursuant to this Authorization may be subject to re-disclosure by the person or organization authorized to receive the information and may no longer be protected by federal privacy regulations upon re-disclosure. Initial: ___________

____ ______________________

Signature of patient or patient's legal representative Date

Name of Representative (please print): ____

Relationship to patient: ____