HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name/s (aka): _____ Social Security Number: _____-_____-_____

I authorize: _____
Name of designated individual, organization, or Provider

_____
Address

To release my health care information to:
Clarendon Vision Development Center, 103 Ogden Ave, Clarendon Hills, IL 60514
Phone 630-323-7300 Fax 630-323-7662
for the purpose of reviewing my records.

Information to be released:

- ☐ All Medical Records
- ☐ All Medical Billing Records
- ☐ X-Ray and Imaging Records

Dates of Treatment:

- ☐ All Dates
- ☐ Specific Dates:_____
- _____

Other: _____

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

This authorization will expire 90 days from the date signed. A copy or facsimile of this authorization shall be counted true and valid as the original.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Signature of Attorney or Witness