113 N. Bridge St.
Chippewa Falls, WI 54729

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(*ALL SECTIONS OF THIS RELEASE MUST BE COMPLETED OR THE RELEASE MAY NOT BE PROCESSED*)

PATIENT NAME: ____ BIRTH DATE: ____/____/______

MAIDEN OR OTHER NAME (S): _______________________________ PHONE NUMBER: ____ - ____ - ______

Records Needed by: ☐ I have an appointment on _______________ ☐ I will pickup on ___________________

Patient/Patient Representative requests only:

☐ Check this box if you do not want your records sent via electronic means
☐ Check this box if you are requesting your entire medical record

I authorize Northwoods Family Eyecare to use or disclose (as applicable) the following information:

(check all that apply)

☐ All Eye Records ☐ Special Tests ☐ Contact Lens Records
☐ Procedure Reports ☐ Glasses Records ☐ Billing Statements
☐ Visual Fields ☐ Retinal Imaging (fundus photos) ☐ Other (specify): ______________________________

Please indicate date(s) of treatment: ____

Health facility, doctor, person(s)
RELEASING Protected Health Information:

☐ FROM or ☐ TO

Northwoods Family Eyecare
113 N. Bridge Street
Chippewa Falls, WI 54729
p: (715)723-9187
f: (715)723-1755
nweyecare@sbcglobal.net

The information described above may be
DISCLOSED/RELEASED to the following recipients:

☐ FROM or ☐ TO

____
Name
____
Address
____
City, State Zip Code
____
Phone or Fax Number

Reason for the use or disclosure (as applicable) is for the purpose of:

☐ Continuing Medical Care ☐ Insurance ☐ Legal
☐ Research ☐ At the Request of the Patient ☐ Other (specify): ___________________________________

- I understand that Northwoods Family Eyecare will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form except if the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Northwoods Family Eyecare will not provide the treatment if I am unwilling to sign this authorization form.
- I understand that I may revoke this authorization by sending a written request for revocation to Northwoods Family Eyecare Privacy Officer. If I revoke this authorization, Northwoods Family Eyecare will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when Northwoods Family Eyecare discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.
- I understand that there may be a fee associated with the release of my medical information.
- I understand that this authorization will expire 12 months from the date signed unless I indicate otherwise here:_________________

____ ________________ ___________________________________
Signature of Patient or Authorized Representative Date (DD/MM/YYYY) Relationship to Patient (e.g. Self, POA)

Patient is Unable to Sign Release: ☐ Minor ☐ Deceased ☐ Other: ___________________________________

(please specify and provide legal paper as needed)