AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION TO DESIGNATED PARTY

This Authorization grants permission to the Designated Party (ies) named below to: make or confirm appointments; have access to x-ray, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up sample medications; be made aware of my condition, diagnosis, prognosis, and treatment plans; and have access to my financial health information.

I hereby authorize DuPage Ophthalmology, SC to disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is released to the Designated Party (ies) named below, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ Date of Birth: _____

Designated party _____ Relationship to Patient:_____

Address:_____ Phone: _____

Designated party _____ Relationship to Patient:_____

Address:_____ Phone: _____

Designated party _____ Relationship to Patient:_____

Address:_____ Phone: _____

The information will be used or disclosed for the following purposes:

θ At the request of the individual θ other: _____

Please read the three statements below carefully before signing this document:

1. I understand that I may revoke this Authorization at any time by notifying the healthcare provider in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by the provider prior to their receipt of the revocation.

2. I understand that my treatment cannot be conditioned on whether or not I sign this Authorization:

3. I understand that this Authorization will: (***Must check one***)
   ( ) expire 1 year from the date executed; or
   ( ) be effective for the lifetime of the patient unless revoked (see #1 above)

_____ _____

Signature of patient or patient's representative **Date**

(*Form will not be valid unless all appropriate blanks are filled)*

Printed Name of Patient's Representative: _____

Relationship to Patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Revised 06/16/2014