MEDICAL EYE
ASSOCIATES

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) | MEDICAL RECORD RELEASE FORM

Patient Name:	**Date of Birth:**
Address:	**City, State, Zip:**
Phone Number:	**Last 4 Digits of SSN:**

I authorize the information to be disclosed by: ☐ Medical Eye Associates S.C. or ☐ Other*
*Agency/Facility/Person to Release Information:
Address: City, State, Zip:
Phone Number: Fax Number:

I authorize the information to be disclosed to:
☐ Medical Eye Associates S.C at N19W23993 Ridgeview Pkwy Ste 100, Waukesha, WI 53188 or Fax: 262-547-9142
☐ Agency/Facility/Person to receive the information:
Address: City, State, Zip:
Phone Number: Fax Number:

Purpose of Disclosure: ☐ Further Medical Care: Relocating ☐ Yes ☐ No
☐ Application for Insurance ☐ Payment of Insurance Claim ☐ Disability Determination ☐ Legal
☐ Personal Reasons/Other:

Information to be Disclosed (check all that apply):
☐ All Records/Information ☐ ER Records ☐ Progress Notes ☐ History & Physical ☐ Outpatient Visit
☐ Billing Statements ☐ Discharge ☐ Operative Report ☐ Verbal/Voicemail ☐ Other:

For the Following Date(s): From: To:
The information to be released via: ☐ US Mail ☐ Fax ☐ Pickup ☐ Verbal/Voicemail ☐ All Methods

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that Medical Eye Associates S.C. may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. **Right to Withdraw This Authorization -** I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Medical Eye Associates S.C. Attn Medical Records, 1111 Delafield St. Ste 312, Waukesha, WI 53188. I am aware that my withdrawal will not be effective until received by Medical Eye Associates S.C. and will not be effective regarding the uses and/or disclosures of my health information that Medical Eye Associates S.C. has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. **MARKETING:** I understand if Medical Eye Associates S.C. uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information. **Right to Inspect or Copy the Health Information to Be Used or Disclosed -** I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Medical Eye Associates S.C. Medical Records Department.
REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.
EXPIRATION DATE: This authorization is good until (indicate date or event) . By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____ DATE: _____

If signed by someone other than the patient, state legal authority:
☐ Legal guardian of patient (proof of guardianship required)
☐ Parent of the above-named minor child and I represent that I have not been denied periods of physical placement with my child by a court.
☐ The legal representative of a deceased patient (proof required)
☐ The agent under an activated Healthcare Power of Attorney (proof and statement of incapacity required)
☐ Other: