Eye Associates
OF ALEXANDRIA

Dr. J. Anderson • Dr. J. Hoven • Dr. M. Hoven • Dr. C. Stotesbery

Authorization To Release Medical Records

Patient Information:

Name (print) _____ Date of Birth _____

Information To Be Released From:

Name of Facility or Provider_____

Information To Be Sent To:

Eye Associates of Alexandria
1610 Broadway Street
Alexandria, MN 56308
Phone: (320) 763-4321
Fax: (320) 763-6921

Requesting Provider _____

Information To Be Released:

____ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
____ All Medical Records
____ Specific Information (please specify): _____

Purpose For Which The Disclosure Is Being Made: (please check one)

____ Attorney ____ Insurance ____ Doctor ____ Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

_____ Drug/Alcohol abuse/treatment & diagnosis
_____ HIV/AIDS diagnosis/treatment/testing
_____ Sexually transmitted disease
_____ Mental Illness or psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reached the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

Signature: _____ Date: _____
(Patient, Guardian*, or Authorized Representative*)

This authorization will expire 90 days from the date signed.