ANTIOCH EYE ASSOCIATES

AUTHORIZATION TO RELEASE INFORMATION

Patientʼs Name: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_ Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_

Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize (referring provider) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to release medical information from my medical record and send it to: Antioch Eye Associates

Connie Crawford, O.D.,P.C.

James Crawford, O.D.

Laura Cretors, O.D.

31 North Ave

Antioch, IL 60002

Phone: 847 395-4090 Fax: 847 395-7378

 I authorize you to release my medical records dating from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I authorized you to release my entire record to the physician named above subject to the following limitations, if any.

" \_\_\_\_\_ No limitations

" " OR (check any of the following)

" \_\_\_\_\_ Only information related to the following is to be excluded:

" " \_\_\_\_\_ HIV/AIDS

" " \_\_\_\_\_ Mental Health

" " \_\_\_\_\_ Substance Abuse

" \_\_\_\_\_ Any medical record from other physicians or providers is to be excluded

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Purpose of release:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient) Date: signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (witness) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_