ILLINOIS EYE INSTITUTE

Patient Information Release Form

Illinois Eye Institute - www.illinoiseyeinstitute.org - 3241 South Michigan Avenue - Chicago, Illinois 60616-3878
Medical Records: 312.949.7206 / Main: 312.225.6200 / Privacy Office: 312.949.7209 / **Fax:** 312.949.7626

To allow the IEI to release protected health information, please complete the following information.

Patient Info

I authorize the Illinois Eye Institute to release certain protected health information identifying me to:

_____

(Name and address of entity to receive this information, if not IEI)

This authorization permits the Illinois Eye Institute to release or disclose the following individually identifiable health information about me.

Information to be released:
- ☐ complete medical record
- ☐ summary of medical record
- ☐ notes of specific date of service
- ☐ other, please specify _____

Purpose of the release of the health information:
- ☐ at my request
- ☐ for my treatment
- ☐ other, please specify _____

This authorization will expire on: ☐ date, please specify _____
☐ at the end of the research study

It is completely your decision whether or not to sign this authorization form. We cannot treat you any differently or refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how to see or get a copy of your health information (your medical record.) If you sign this authorization, you can revoke it later unless the information has already been released based upon this authorization. Revocation must be submitted in writing to the Illinois Eye Institute's Privacy Officer at 3241 S. Michigan Ave, Chicago IL, 60616. When your health information is released as provided in this authorization, the recipient of your information often has no legal duty to protect its confidentiality. There is the potential that the recipient may re-release the information.

Print Patient Name: _____ **DOB:** _____ /_____ /_____
Patient's Address: _____ **Phone:** _____
Signature of Patient: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ **Print Name:** _____
Source of Authority: _____
(You may be asked to provide documentation of this relationship to the patient)

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION

FOR IEI USE: Patient Contacted:_____ /_____ /_____ Appt. Made _____ /_____ /_____ at _____ Report sent to referring doctor_____ /_____ /_____
Additional Info: _____