St. Cloud Eye Clinic

COMPREHENSIVE EYE CARE FOR OVER 80 YEARS

Authorization for Release of Medical Information

Steven W. Rice, M.D., F.A.C.S.
Richard W. Lucius, M.D., F.A.C.S
Bradley M. Anderson, M.D.
Mitchell D. Harstad, O.D.

I hereby authorize the release of information from the medical record of:

Patient Name ______________________________ Date of Birth ______/______/______
Last First MI

Social Security #: ______________ Daytime Phone Number______________ Alternate Phone Number ______________

Information Released To: Valid until ____/____/____ Information Released From: Valid until: ____/____/____

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Please Release the Following:

- ☐ Problem List
- ☐ Progress Notes
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ History/Physical Exam
- ☐ EKG Reports
- ☐ Lab Reports
- ☐ Immunizations
- ☐ Other Diagnostic Reports (Specify)______________
- ☐ Other (Specify) ______________

Including information (if applicable) pertaining to:

- ☐ Mental Health
- ☐ Drug/Alcohol
- ☐ HIV/AIDS
- ☐ Communicable Treatment

Purpose of Need for Disclosure:

- ☐ Continued Patient Care
- ☐ Attorney/Legal
- ☐ Personal Use
- ☐ Insurance Claim/Application
- ☐ Disability Determination
- ☐ Other (Specify) ______________

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

______________________________ ______________________________

Signature of Patient or Legal Representative Date

______________________________ ______________________________

Relationship to Patient Witness

Complete only if information is to be released directly to patient:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold St. Cloud Eye Clinic, P.A. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

______________________________ ______________________________

Signature of Patient or Legal Representative Date

______________________________ ______________________________

Relationship to Patient Witness

Date request completed ____/____/______ # pages copied______________ Initials______________

St. Cloud Eye Clinic
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