Chippewa Valley Eye Clinic, Chippewa Falls, SC

Practice limited to medical and surgical diseases of the eye

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Chippewa Falls, WI 54729
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Authorization to Release Protected Health Information Form

Patient Information:

Patient name (including maiden/other) ____________ Date of Birth ____________ Telephone # ____________

Street Address / Fax number / Other ____________ City ____________ State ____ Zip ____

I authorize and give my permission for:

Name of Physician and credentials / type of provider ____________

Organization/ Name ____________

Street Address ____________

City ____________ State ____ Zip ____

To release my protected health information described below to:

Name of Physician / attention to ____________

Organization Name ____________

Street Address / Fax number / Other ____________

City ____________ State ____ Zip ____

Method to release my protected health information (PHI):

❑ Verbal ❑ Fax ❑ US mail ❑ Pickup (in person)

I would like to personally receive a copy of my PHI in the following format:

❑ Fax ❑ Hard copy

❑ Other (please specify): ____________

I understand if the organization is not able to provide a copy in the format requested, I will be contacted to discuss other options.

Information (PHI) to be released:	Date of Service		Date of Service
❑ All Clinic Records	________	❑ Allergy Records	________
❑ Eye Records	________	❑ Lab Reports	________
❑ Office Notes	________	❑ X-Ray Reports	________
❑ Photographs	________	❑ X-Ray Films (Specify)	________
❑ Visual Fields	________	❑ Electrocardiograms	________
❑ Immunization Records	________	❑ Developmental Disabilities	________
❑ Other (please describe)	________		

The purpose(s) of this release is:

❑ Further medical care
❑ Insurance change
❑ Insurance eligibility/benefits
❑ Changing providers (please explain): ____________

❑ Insurance/billing resolution
❑ Vocational rehabilitation evaluation
❑ Disability determination
❑ Workers Compensation

❑ Attorney/court case/legal investigation
❑ Personal use
❑ Relocation/moving
❑ Other (comments): ____________

This authorization to release my protected health information (PHI) is effective until the following expiration date or event __________________. If I do not list an expiration date or event, this authorization will expire one (1) year from the date signed.

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I am not required to sign this form in order to be provided treatment, payment, enrollment in a health plan, or eligibility for benefits. The persons(s) I am authorizing to receive my PHI may release my PHI without my knowledge and may not be required to follow federal or state privacy standards. The persons(s) I am authorizing to receive my HIV test results, however, may not release these results unless authorized or allowed by law. I may be charged a fee before I receive copies of my PHI.

I may cancel this authorization to release my PHI by completing and sending Chippewa Valley Eye Clinic, Chippewa Falls, SC's Cancel and Authorization to Release PHI form to Chippewa Valley Eye Clinic, Chippewa Falls, SC's Privacy Officer. Cancellation does not apply to PHI already released in response to this authorization.

I understand what PHI about me will be released. This accurately reflects my wishes.

Signature of Patient or Legal Representative* ____________________ Date ____________________

***Name of the Legal representative completing this form:** ____________________

Legal authority*: ❑ Parent **By signing above, I am confirming that I have not been denied physical placement of this child

❑ Legal guardian ❑ Next of kin / executer of deceased ❑ Activated POA for Health Care ❑ Other: ____________________

For Chippewa Valley Eye Clinic, Chippewa Falls, SC's Internal Use Only		
Date received:		❑ **Copy of this form was provided to individual**
Description of PHI released:		
PHI Released by:		

Name of workforce member ____________________ Title ____________________ Signature ____________________ Date & time released ____________________

Original: chart Copy: Patient/legal representative