Chippewa Valley Eye Clinic, Chippewa Falls, SC

Practice limited to medical and surgical diseases of the eye

2525 County Hwy I
Chippewa Falls, WI 54729
715-723-9375(telephone)
715-723-1092(fax)

Peter W. Holm, M.D.
Jeffrey F. Brown, M.D.
Terrence D. McCanna, M.D.

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/billing resolution	☐ Attorney/court case/legal investigation
☐ Insurance change	☐ Vocational rehabilitation evaluation	☐ Personal use
☐ Insurance eligibility/benefits	☐ Disability determination	☐ Relocation/moving
☐ Changing providers (please explain):	☐ Workers Compensation	☐ 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.

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