· CHIPPEWA VALLEY ·
EYE CLINIC
2525 COUNTY HWY I
CHIPPEWA FALLS, WI 54729

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FORM

PATIENT INFORMATION:

Patient Name (Including Maiden/Other) _____ Date of Birth _____ Telephone Number _____

Street Address/Fax Number/Other _____ City _____ State _____ Zip _____

I AUTHORIZE AND GIVE MY PERMISSION FOR:

Physician Name and Credentials/Type of Provider _____

Organization Name _____

Street Address _____

City _____ State _____ Zip _____

TO RELEASE MY PROTECTED HEALTH INFO DESCRIBED BELOW TO:

Physician Name/Attention to _____

Organization Name _____

Street Address _____

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

INFO (PHI) TO BE RELEASED:	DATE OF SERVICE:	INFO (PHI) TO BE RELEASED:	DATE OF SERVICE:
☐ All Clinic Records	_____	☐ Immunization Records	_____
☐ Eye Records	_____	☐ Allergy Records	_____
☐ Office Notes	_____	☐ Lab Reports	_____
☐ Photographs	_____	☐ X-Ray Reports	_____
☐ Visual Fields	_____	☐ X-Ray Films (Specify)	_____
☐ Electrocardiograms	_____	☐ Developmental Disabilities	_____

☐ Other (please describe): _____

THE PURPOSE(S) OF THIS RELEASE IS:

☐ Further Medical Care
☐ Insurance Change
☐ Insurance Eligibility/Benefits
☐ Insurance/Billing Resolution
☐ Vocal Rehabilitation Evaluation
☐ Changing Providers (please explain): _____

☐ Disability Determination
☐ Attorney/Court Case/Legal Investigation
☐ Personal Use
☐ Relocation/Moving
☐ Workers Compensation
☐ Other (comments): _____

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FORM

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:

☐ Legal Guardian ☐ Next of Kin/Executer of Deceased ☐ Activated POA for Health Care

☐ Parent**

***By signing above, I am confirming that I have not been denied physical placement of this child*

☐ 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