# AUTHORIZATION TO RELEASE INFORMATION[1]

Patient Name_____ D.O.B._____/_____/_____ SSN #_____/_____/_____

I authorize_____
Name Address

To disclose the information described below to

_____
Name Address

Specific description of information (including date(s) of service)
*If information includes mental health treatment, substance abuse treatment or HIV-related information it will not be released unless the reverse side of this form is completed.*

_____

_____

_____

The disclosure is for the following purpose(s)_____

_____
*If the disclosure is at the request of the patient, then indicate on the line above, or specify other purpose (i.e., marketing; research)*

This release is for marketing purposes and Prairieland Eye Clinic is being compensated for the disclosure by _____

_____
*Strike the above provision if not applicable.*

This release expires on _____/_____/_____ or one year from the date signed.

I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services unless the services are at the request of the party to whom the protected health information will be disclosed. I also understand that if I revoke, the revocation will take effect on the day it is received in writing as explained in our notice of privacy practices as provided to you.

I further understand that, except in the case of substance abuse, mental health, or AIDS-related information, if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not a business associate of these entities, the information described above may be redisclosed and will no longer be protected by the regulations.

_____ Date_____/_____/_____
Signature of Patient or Patient's Legal Representative

Printed name of patient's legal representative_____

Relationship to the patient_____

[SIDE A]

[1] This authorization was drafted to comply with the Federal HIPAA privacy rule and applicable Iowa law.

# Prairieland Eye Clinic
# Consent to Release Medical Information

**Under the federal Health Information Portability and Accountability Act or HIPAA, your health records are confidential information between you and your health care provider if you are 18 years of age or older**

**Patient Name:** _____ **Date of Birth:** _____

**Acknowledgement of Receipt of Practice's Notice of Privacy Practices:**
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

**Consent to Disclose My General Health Information:**
By my signature below, I herby authorize Prairieland Eye Clinic Doctors and staff to disclose my medical information so that the practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations. I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me; seek payment for that treatment and for the purpose of their health care operations. I also authorize the Practice to disclose my medical information on my home answering machine or personal voicemail.

**I authorize Prairieland Eye Clinic Doctors and staff to disclose my medical information to the following family members/friends:** _____
_____

**Assignment of Insurance Benefits and Responsibility of Payment:**
By my signature below, I authorize medical benefits to be paid to Prairieland Eye Clinic on my behalf for services rendered to me. I understand that insurance explanation of benefits will be provided to the owner of the insurance policy by the insurance company. I understand that I am responsible for any charges not covered by my insurance plan for this date as well as any future service dates.

_____ _____ _____
*signature of patient* *date* *release expiration date*