Apple Valley Eye Care

Authorization to release and discolose patient information

Patient Information

Name _____ **Date of Birth** _____

Address _____ **Best Phone** _____

City _____ **State** _____ **Zip Code** _____

Clinic / Health Care Provider (who has the information you want released?)

Name Apple Valley Eye Care **Phone** 952-432-0680

Address 7789 147th Street West **Fax** 952-432-8823

City Apple Valley **State** MN **Zip Code** 55124

Information to be Released

- ☐ Clinic (office visit, refractive eye exams, specialty testing)
- ☐ Billing Records

Release Instructions (where you want the records sent to)

Name _____ **Phone** _____

Address _____ **Fax** _____

City _____ **State** _____ **Zip Code** _____

Date information is needed: _____ (please allow 72 hours processing)

Purpose for Release (check applicable)

- ☐ Continuing Care
- ☐ Personal use or review
- ☐ Litigation / legal
- ☐ Transfer of Care
- ☐ Insurance application
- ☐ Insurance application
- ☐ Social Security appeal
- ☐ Social Security disability determination
- ☐ Other

* Apple Valley Eye Care will not restrict my treatment if I choose not to sign this authorization
* This authorization may be canceled in writing at any time. A cancellation will not change the releases that happen before the cancellation.
* A photocopy or fax of this authorization will be treated in the same way as the origial.
* Apple Valley Eye Care cannot prevent redisclosure of your information by the person or organization who receives your records. In some cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.
* This authorization lasts for one year after the date it is signed unless you enter a different expiration date here: _____
* By signing this form, you release Apple Valley Eye Care from any and all liability from a redisclousre by the recipient.
* Your signature indicates that you have read and understand this form, and authorize release of your information as described above

_____ _____ _____

Patient / Legal Guardian Signature | Date | Authority to act on behalf of patient

(attach document)