AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ____________________

Previous Name: ______________________________ Phone #: ____________________

Address: ______________________________ City / State / Zip: ____________________

I request and authorize (previous provider) ______________________________

To release healthcare information of the patient named above to:

Dr. Chris Olson / Olson Eye Care

320 McKenzie Ave. Suite 206

Council Bluffs, IA 51503

P: 712-256-1111 / F: 712-256-1549

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates: ______________ ______________________________
- ☐ All healthcare information
- ☐ Other: ______________________________

I understand I may revoke this authorization at any time and if I revoke this authorization I must do so in writing and present my written revocation to Olson Eye Care. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ________________/ if i fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X______________________________ Date: ________________

Signature of Patient / Parent / Guardian or Authorized Representative

(Guardian or Authorized REpresentative must attach documentation of such status.)

______________________________ ______________________________

Printed name of Authorized Representative Relationship to patient

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Address and telephone number of authorized representative