Eye Center of the Dakotas

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

701-224-0661 Fax: 701-224-0663
1221 W. Divide Avenue, Suite 1, Bismarck, ND 58501

Patient Name _____ Maiden/Other Name _____

Address_____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Date of Birth _____ SSN _____ - _____ - _____

I authorize the Eye Center of the Dakotas to SEND my medical records TO:

Name_____

Address _____

I authorize the Eye Center of the Dakotas to OBTAIN my medical records FROM:

Name_____

Address _____

Information to be Released

Unless you tell us otherwise, the Eye Center of the Dakotas will send/request the last two years of medical history.

Other information you want sent/obtained (please be specific):

_____

_____

This information is requested for the following purposes:

_____ Diagnosis and Treatment _____ Military

_____ Insurance/Billing _____ Personal

_____ Legal _____ Other_____

Your Rights With Respect to This Authorization

1. This authorization will remain effective until the following date, event or condition: _____
If there is no date, event or condition, it will remain effective for 1 year and will automatically expire without my express revocation. I understand that I can revoke this authorization at any time upon request. Any information released prior to my written revocation of this authorization will not be a breach of confidentiality.

2. I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed under this authorization.

3. I understand that if I sign this authorization, I have a right to receive a copy of it.

4. I understand that I am under no obligation to sign this form and the action requested in this release will not be executed without a signature. Medical treatment to the patient is not conditioned on the signing or failure to sign this form.

5. I understand that if the individual or organization that receives this information is not a healthcare provider or health plan covered by the federal privacy regulations, the information released to the above may be redisclosed and is no longer protected by these federal regulations.

Signature _____ Date _____

Witness_____ Date _____

If you are not the patient signing this form, what is your relationship to the patient?

_____