Family Eye Care
Dr. Robert Christ & Dr. Nancy Alexander
1871 S. Randall Road Suite A
Geneva, IL 60134
Phone: (630)377-2020
Fax: (630) 402-0527

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Please read this form carefully. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which became effective April 14' 2003, requires that all of the following elements must be completed for an authorization to be valid.

Patient Name: _____ Date of Birth: _____

Street Address: _____

City, State, & Zip code: _____

Phone Number: _____

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Organization: _____

Address: _____

City _____ State: _____ Zip: _____

TO: **Dr. Robert Christ / Dr. Nancy Alexander**

Address: 1871 S. Randall Road Suite A

City: Geneva State: IL Zip: 60134 Ph: (630)377-2020 Fax: (630)402-0527

☐ Please release all available records
☐ Please release spectacle RX
☐ Please release contact lens RX
☐ Please release records from the period dating from _____ to _____
☐ Please release ONLY the portions of my medical records checked below:

☐ Medical History
☐ Last complete eye exam
☐ Photos
☐ Visual Fields
☐ Correspondence to/from other doctors
☐ Other: _____

I understand that I must check one of the following types of health information if I do not want it released to the above-named recipient. I understand that if I do not check any of the following three items, the health information released to the named recipient may include any of the following:

_____ Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse

_____ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis, and/or treatment

_____ Psychiatric, psychological records or evaluation and or treatment for mental, physical, and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

I also understand that this Authorization is valid for one (1) year from the date that it is signed. I may revoke this consent at any time through ***written notice***.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian/Personal Representative Relationship to Patient