AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name (First, Last): _____ _____
Date of Birth: _____
Telephone: _____

Address:_____
City/State/Zip: _____ _____ _____
Guardian/Parent Name: _____

I authorize (select one):

Address: 817 E 66th Street, Richfield, MN 55423
Telephone: (612) 488-1566
Fax: (612) 488-1564
Email: Info@SwoopEye.com

☐ To release information to (sending):
☐ To obtain information from (receiving):

Listed Clinic/Provider/Organization:

_____ _____ _____
Name **Fax Number** **Phone Number**

_____ _____ _____ _____
Address **City** **State** **Zip**

I hereby authorize the release & communication of information both written and verbal between this office (above) and the party named above in all matters concerning the history and any examination, treatment and/or care of the patient.

Requested Records *(select all that apply)*
☐ Eye Exam Record ☐ All records
☐ Imaging (MRI/CT/X-Ray) ☐ Lab Testing
☐ School/IEP report(s) ☐ Other: _____

Authorization (select one): I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will remain active unless an expiration date has been designated or by written revocation (via letter, email) by the patient or guardian of the patient. A copy of this authorization may be used with the same effectiveness as an original.

Indefinite (ongoing): ☐ ***Expiration Date:*** ☐ _____

HIPAA Required Statements:

- I understand that non-research treatment may not be conditioned upon signing this release.
- I understand that the information provided under this release may be subject to redisclosure by the recipient under circumstances no longer protected by HIPAA privacy rules.
- I understand that I may revoke this release at any time***, except to the extent that action has already been taken to comply with it***. To revoke this authorization, I must provide written notice to the health plan, doctor or health care provider (*email provided above or certified letter*) named in this release and written notice to the organization or entity to whom I have authorized the release of information.

Patient Signature: _____ **Date**: _____

Authorized Guardian: _____ **Date**: _____ **Relationship to Patient**: _____