ARLINGTON EYE PHYSICIANS

1604 WEST CENTRAL ROAD ARLINGTON HEIGHTS, IL 60005-2407 PHONE 847 394-1414 FAX 847-418-8928

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATON

You may fax your completed forms to 847-418-8928

Patient Name_____ Date of Birth_____
Street Adress_____
City_____State_____Zip Code_____
Phone_____ Email_____

I AUTHORIZE ARLINGTON EYE PHYSICIANS TO RELEASE TO:

Name_____
(If an individual, describe the relationship to the patient)
Street Address_____
City_____State_____Zip Code_____
Phone_____Fax_____

THE FOLLOWING INFORMATION FROM THE ABOVE-NAMED PATIENT'S RECORD

Please check off appropriate box(es)

☐ Records from a specific date range From_____ To_____
☐ All Records

Purpose/need for information (specify the use of the information to be disclosed: _____
_____

I understand and agree that I am financially responsible for any record copy fees (if applicable).

_____
Signature of patient or authorized legal guardian Date

_____
Relationship to patient, if signed by authorized representative Date

_____
Signature of witness (if applicable) Date

NOTICE TO PATIENT: I understand that this consent is valid for 90 days from the date of signature, or until calendar date ___/___/___. I understand that as set forth in Arlington Eye Physicians notice of Health Information practices, that I may revoke this authorization at any time by giving written notice to the Medical Record Department of Arlington Eye Physicians except to the extent that Arlington Eye Physicians has already acted in reliance on this contract. This authorization will automatically expire when the information requested has been disclosed if I have given no prior notice as stated above. I understand I have the right to review and obtain the information to be disclosed. I understand that information disclosure pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. For psychiatric, psychological, and social work records, Release of Information regulations as stated in the Illinois Mental Health Confidentiality Act will take precedence.