ILLINOIS eye CENTER
Your Vision Empowered

Patient Name _____
DOB _____
Account No. _____

MEDICAL INFORMATION RELEASE AUTHORIZATION

I hereby authorize Illinois Eye Center to release information regarding my protected health information to the following persons and/or agency. I also give my permission to Illinois Eye Center to communicate information regarding my appointment time or any possible changes to my scheduled appointment to the persons listed below.

Emergency Contact. This person is also Authorized for HIPAA Release:

(Emergency Contact / HIPAA)	(Relationship)	(Phone – Required)

Additional HIPAA Authorizations:

Name:	Relationship:	Phone (optional):

How Illinois Eye Center may contact me personally:

Messages may be left at these numbers: ☐ Cell ☐ Home ☐ Work

Patient Information

I have the right to revoke this authorization at any time by notifying Illinois Eye Center in writing. This authorization will not expire until then. The revocation will not apply to information that has already been released in response to this authorization. Information obtained by individuals on this authorization may be subject to redisclosure by the recipient(s).

Signature: _____ **Date:** _____

****If Signed by a Legal Representative, Relationship to Patient:** _____