ILLINOIS eye CENTER
PEORIA • WASHINGTON • PEKIN

8921 North Wood Sage Road
Peoria, IL 61615
(309) 243-2400

AUTHORIZATION FOR RELEASE OF INFORMATION

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.

The Practice will only include information used to make decisions about the patient. The Practice may limit access to information generated only by the Practice. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold the requested information. The Privacy Officer of this Practice will evaluate this Request and notify the patient of our decision within fifteen (15) days of the Request. If the Request is approved, the Practice will provide the information within thirty (30) days or within sixty (60) days if such an extension is necessary. The Practice may provide a summary of the requested information if you are agreeable.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Name: _____ **DOB**: _____ **Acct No** (office use only) _____

Patient's Address: _____

City: _____ **ST**: _____ **Zip**: _____

Home Phone #:_____ **Alternate Phone #**: _____

I hereby authorize **Illinois Eye Center** to send/release photocopies of medical records concerning the above named patient to NAMED RECEIVER LISTED BELOW.

(NAME OF COMPANY / PHYSICIAN / AUTHORIZED PERSON / TO RECEIVE/RELEASE RECORDS)

Name: OSF Healthcare Children's Hospital of Illinois – Pediatric Ophthalmology (Dr. Lichtenstein/Dr. Vahey)

Address: 4927 N. Glen Park Place

City: Peoria **ST**: Illinois **Zip**: 61614

Phone # 309-308-3500 **Fax #** 309-623-4365

Records to be released (no fee):

_____OSF Requested Records for Pediatric Ophthalmology

Additional records to be released (with fee):

_____Other (please specify) _____

_____Records from _____ to _____
Date Date

_____ Full Medical Records

_____ Copy of Contact Lens Prescription

_____ Copy of Glasses Prescription

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Reason for the request:

_____Transfer of Care

_____Other (Comment if Applicable) _____

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to Illinois Eye Center, 8921 N. Wood Sage Rd, Peoria, IL 61615. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Privacy Officer at the above address.

Illinois Eye Center does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is **solely** for the purpose of creating a medical report for a third party, if authorization to release the information to the third party is not provided, it may result in the cancellation of those services.

I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

Substance Abuse _____ Mental Health _____ HIV-related information _____ Genetic tests/info _____

I am aware that there may be a charge for the copying of records. If so, the State of Illinois fee schedule is used to determine the cost.

This agreement will expire one year from the date of signature, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

Signature of Patient: _____**Date Signed**: _____

Signature of Authorized Person: _____**Date Signed**: _____
(If applicable)

If signed by other than patient, state relationship and authority to do so.

Legal Authority: ____Legal Guardian (Attach court action) ____Parent of Minor ____Power of Attorney (Attach POA papers)

You may return your completed AUTHORIZATION FOR RELEASE OF INFORMATION form by:

1. **Mail** Illinois Eye Center
   Attn: Medical Records
   8921 North Wood Sage Road
   Peoria, IL 61615
2. **Fax** 309.243.7918
   (Please mail color images)
3. **Email** medicalrecords@illinoiseyecenter.com

FAILURE TO COMPLETE RELEASE PROPERLY MAY RESULT IN YOUR REQUEST BEING DELAYED OR RETURNED TO YOU BECAUSE OF INABILITY TO PROCESS.

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