GROSSNICKLE
Eye Center

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

PATIENT:

_____ _____
Name of Patient/Previous Names Birth Date

_____ _____
Address Phone Number

AUTHORIZES:

_____ _____
Name of Health Care Provider Phone Number

_____ _____
Address Fax Number

TO RELEASE MEDICAL RECORDS TO:

GROSSNICKLE EYE CENTER, INC.,

□ 2251 Dubois Dr., Warsaw, IN 46580
Phone: (574) 269-2777 **Fax**: (574) 371-4697

□ 1510 Osolo Road, Elkhart, IN 46514
Phone: (574) 266-6100 **Fax**: (574) 266-8708

□ 4330 Edison Lakes Parkway, Suite A, Mishawaka, IN 46545
Phone: (574) 271-0120 **Fax**: (574) 273-4108

INFORMATION TO BE RELEASED:

□ **ENTIRE RECORD** □ Exam Reports □ Operative Reports □ Laboratory Reports

□ All ophthalmic testing □ Consultations □ Imaging Reports

□ Other (Specify):

_____

For the Following Dates: _____

PURPOSE FOR DISCLOSURE: _____

I understand that I may revoke this authorization at any time in writing, except to the extent action has been taken. The authorization will be valid until revoked, upon expiration of the above date, or after sixty days, whichever comes first. I understand I am giving permission to use/disclose PHI which may include treatment for physical/emotional illness, communicable diseases, alcohol/drug abuse treatment, and/or HIV/AIDS or AIDS related information. I understand the information may be subject to re-release by the recipient and may no longer be protected by any privacy rules or regulations.

Signature: _____ Date: _____
(If not patient-State Relationship to Patient)