RELEASE OF ESA RECORDS
CONSENT TO RELEASE OF INFORMATION
Eye Surgeons Associates, P.C. (ESA)

ESA Chart # _____

Patient Name _____ Date of Birth _____

I understand that by signing this form I am allowing ESA to release medical information concerning the above-named patient to:

_____

Name of Person and/or Institution

_____

Complete Mailing Address/Street/P.O. Box City, State, Zip Code

As per my request, reason for release of information: _____

Check the information to be disclosed (Include dates where indicated)

☐ Last 3 visits are free _____

☐ Operative Notes (Specify date) _____

☐ Laboratory results, specify types or dates _____

☐ Billing Information _____

☐ All office notes _____

Handling and process fee may apply

☐ Other (Specify) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Eye Surgeons Associates P.C., Medical Records Department, 4731 45th Street Court, Rock Island, IL 61201. I understand that any release that was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Discloser of this information carries with it the potential for unauthorized redisclosure and 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 Director of Administrative Services at the above address.

I understand that ESA may not require completion of this form as a condition of treatment. However, when the provision of service is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that the information to be released 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 _____

This consent is valid for medical records accumulated through the date of authorization only, unless previously revoked or other wise indicated.

_____

Signature of Patient or Legal Guardian Date Phone Number

_____

Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____

Relationship, if Not the Patient Witness Signature