

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

ESA Chart # _____
Completed _____ (Date & Initials)

Patient Name _____ Date of Birth _____

I understand that by signing this form I am allowing: (Name and complete address of doctor or clinic)

to release medical information concerning the above-named patient to:

Eye Surgeons Associates, P.C.
4731 45th Street Court
Rock Island, IL 61201
Attn: Medical Records Fax: (309) 792-3910

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

- All office notes or specify specific dates _____
- Consultation Reports _____
- Operative Notes _____
- Diagnostic Reports (Please specify type) _____
- X-Rays and External Photos _____
- Laboratory results, specify types or dates _____
- Billing Information _____
- Other (Specify) _____

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

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. Disclosure 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 Medical Records Department 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 otherwise 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	