RELEASE OF ESA 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 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: _____

ESA will provide the last 3 visits unless otherwise indicated below.

☐ Other (Specify. Include dates where indicated.):

_____

_____

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