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319-362-EYES (3937)
Fax 319-362-2900

AUTHORIZATION TO RELEASE INFORMATION

Name _____
Date of Birth _____
Chart Number _____

I, the undersigned, hereby authorize Iowa Eye Center to disclose and/or deliver to:

(name of person or institution)

(address)

A copy of the clinical notes pertaining to my evaluation and treatment and copies of the following information as indicated (if additional information is necessary):

___ History	___ X-ray reports
___ Physical	___ Laboratory reports
___ Problem List	___ Other information as indicated
___ Medication List	_____

The information is to be used for: (please specify reason for release of information, i.e. continuing medical care, second opinion, etc.)

This authorization will automatically expire one year from the date of signature, except as specified: _____
(specify number of days/months). At that time, no express revocation shall be needed to terminate my consent.

I understand that I may revoke this consent at any time by sending a written notice to Iowa Eye Center, 1650 First Avenue N.E., Cedar Rapids, Iowa 52402. I understand that any release which has been made prior to receipt by the institution of my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the Practice Administrator at Iowa Eye Center.

Signature of Patient or Legal Guardian

Date

Address

City

State

ZIP

Relationship to Patient

Witness

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to: (check the appropriate box)

1. Substance Abuse (alcohol/drug abuse)
2. Mental Health (includes psychological testing)
3. HIV-Related information (AIDS related testing)

Signature of Patient or Legal Guardian

Date

Information Sent _____ By _____