Iowa Eye, P.C.
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IOWA EYE
CENTER

Medical | Surgical | Optical
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AUTHORIZATION TO OBTAIN INFORMATION

Name_____ Information Sent For

Date of Birth_____

Chart Number _____ _____
Date

I, the undersigned, hereby authorize Iowa Eye Center to obtain from

_____
(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	_____	Ophthalmic Information
_____	Medication List	_____	Other information as indicated
_____		_____	

I understand that I may revoke this consent at any time by sending a written notice to _____ _____. I understand that any release which has been made prior to my revocation and which was made in this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting Iowa Eye Center.

This authorization will automatically expire sixty (60) days from the date of signature, except as specified:_____ At that time, no express revocation shall (specify number of days/months) be needed to terminate my consent.

SPECIFIC AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION AND/OR DRUG/ALCOHOL ABUSE INFORMATION

X_____
Signed Date

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law and that address is applicable to EITHER mental information or Drug/Alcohol Abuse or BOTH. My signature authorizes release of all such information (as specified above).

_____
Address

X _____ _____
Signature Date Witness

In order for the above information to be released, you must sign here and to the right.

_____
Relationship