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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 institu	ition)	
	(address)		
A copy of the clinical notes pertaining to my evaluation a additional information is necessary):	nd treatment and o	copies of the following information as indica	ted (if
History		X-ray reports	
Physical		Laboratory reports	
Problem List Medication List		Other information as indicated	
The information is to be used for: (please specify reason for	r release of informa	ation, i.e. continuing medical care, second opi	inion, etc.)
I understand that I may revoke this consent at any time I Cedar Rapids, Iowa 52402. I understand that any release and which was made in reliance upon this authorization that I may review the disclosed information by contacting Signature of Patient or Legal Guardian	which has been not shall not constitute	nade prior to receipt by the institution of my reach of my rights to confidentiality. I u	revocation
Address	City	State ZIP	
Relationship to Patient		Witness	
SPECIFIC AUTHORIZATION FOR RELEASE O	F INFORMATION	PROTECTED BY STATE OR FEDERAL LA	W
I specifically authorize the release of data and information	on relating to: (che	ck the appropriate box)	
Substance Abuse (alcohol/drug abuse)			
2. Mental Health (includes psychological testing)			
HIV-Related information (AIDS related testing)			
Signature of Patient or Legal Guardian		Date	
Information Sent	By		