Iowa Eye, P.C.
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IOWA EYE
CENTER

Medical | Surgical | Optical
1650 First Avenue, N.E.
Cedar Rapids, Iowa 52402
319-362-EYES (3937)
Fax 319-362-2900

AUTHORIZATION TO **OBTAIN** INFORMATION

Name_____

Date of Birth _____

Chart Number _____

Information Sent For 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	_____ Medication List	_____ X-ray Reports
_____ Physical	_____ Laboratory Reports	_____ Ophthalmic Information
_____ Pathology Reports	_____ Entire Medical Record	_____ Other information as indicated

Please check the reason for release below; and provide a date by which the info is needed:_____

Insurance ____ 2nd opinion ____ Disability ____ Personal file ____ Moving out of area ____ Legal ____

Other medical care ____ Transferring care ____

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 TO OBTAIN 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_____