The Eye Centers of Racine & Kenosha

**Medical Information Release Form- HIPAA**

Patient Name: _____Date of Birth: _____

**Release of Information**

□ I authorize the release of information including the diagnostic, records of examination rendered to me, and claims information. This information can be released to:

□ Spouse: _____
(Include name and phone number)

□ Child (ren): _____
(Include name and phone number)

□ Other: _____
(Include name and phone number)

□ This information is not to be released to anyone.

**Messages**

Please call: □ Home Phone □ Cell phone □ Work number

If unable to reach me:

□ you may leave a detailed message

□ please leave a message asking me to return your call

□ Other:

_____

_____ _____
Patient or legal representative signature Date

_____ _____
Print name Relationship (if signed by other than patient)

This release of information will remain in effect until terminated by me in writing.