AUTHORIZATION FOR RELEASE OF INFORMATION

Whiting Clinic
LASIK • EYE CARE

Ph: 952.475.3787 F: 952.475.3680

Whiting Clinic Lasik + Eye Care
7415 Wayzata Blvd
St Louis Park, MN 55426

Patient's Name: _____

Birthdate: _____ Phone Number: _____

This will authorize ___Whiting Clinic_____
(Name/Dept/Address)

to release information to _____
(Name/Title of Person/Organization)

_____
(Address) (City) (State) (Zip)

Information to be released includes records from the following dates:_____

Information to be released:

_____ Cardiac Test Results
_____ Consultation Reports
_____ Discharge Summary
_____ EKG Reports
_____ Emergency Department Reports
_____ History & Physical Examination
_____ Laboratory Reports: _____
_____ Nurses Notes
_____ Operative Reports
_____ Pathology Reports
_____ Physician Orders
_____ Physician Progress Notes
_____ Radiology Films
_____ Radiology Reports
_____ Other (specify):
_____

Reports released may include information about mental status/drug/alcohol and HIV testing results. If there is specific information that you do not want released, please write here:

_____

_____

The information is needed for the following purpose: _____

Information to be released via: ☐ Mail ☐ Pick-up ☐ FAX ☐ Courier ☐ Review Only

This authorization will expire upon the earliest of the following dates: 1) twelve months following date of signature on this form, 2) the date the stated purpose is fulfilled, 3) the date I write here _____, 4) the date that I revoke this authorization. I understand that I may revoke this authorization at any time by writing a statement to the authorized releaser as noted above except to the extent that Whiting Clinic has relied on the authorization. A photocopy or facsimile of this authorization shall be treated as valid as the original. I understand that once this information is disclosed, it may no longer be protected under the Federal Privacy Regulations and that the recipient might redisclose the information.

_____ Date: _____
Signature of Patient or Patient's Representative — Must be filled in

(If Patient's Representative, under what legal authority are you signing?)

☐ Parent ☐ Guardian ☐ Health Care Agent
☐ Other (specify): _____