AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____
Last First MI Maiden or Other Name

Date of Birth: _____/______/_______ Phone: ________________ ________________
Day Evening

Address: ____
Street Address City State Zip

I hereby authorize the release of information from my medical record as indicated below:

Release My Medical Record ☐ **From** ☐ **To**	Release My Medical Record ☐ **From** ☐ **To**
Name: ____________________________	**Name**: St. Paul Eye Clinic, P.A.
Address: ____________________________ Street Address ____________________________ City State Zip	**Address**: 2080 Woodwinds Drive, Suite 110 Woodbury, MN 55125 **Phone**: 651-738-6500 **Fax**: 651-738-6804 **Secure Email**: scanning@stpauleye.com
Phone: ______________Fax: ______________	**Records can be sent via encrypted email depending on file size. Please list an email if you would like us to consider emailing your records.*
Email: ____________________________	

Information to be Released:

☐ All Eye Records– *3 years of most recent records & color imaging*
☐ Diagnostic Imaging – *3 years of most recent records (mail in color)*
☐ Medical records from _________ to __________
☐ Other: ____

I specifically authorize the release of information related to:

☐ Substance abuse (including alcohol/drug use)
☐ Mental health (including psychotherapy notes)
☐ HIV related information (AIDS related testing)
Initials: _________

Purpose of Disclosure: ☐ Changing Physicians ☐ Continuing Care ☐ Second Opinion ☐ Other_______________

I understand that this authorization may be revoked, at any time, by sending written notice to the disclosing provider. If the disclosing provider is St. Paul Eye Clinic, this revocation notice should be directed to the St. Paul Eye Clinic Privacy Officer at 2080 Woodwinds Drive, Suite 110, Woodbury, MN 55125. If I revoke this authorization, the disclosing provider will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that once health information is disclosed pursuant to this authorization, the information may be subject to redisclosure by the recipient and may no longer be protected by the Federal or state privacy regulations. I understand authorization for disclosure of my medical information is voluntary. I can refuse to sign this authorization and I understand that the provider will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization form, except if the medical information to be disclosed will result from (i) treatment for research purposes; or (ii) treatment provided to me solely for the purpose of creating information to be disclosed to a third party.

This authorization will remain in effect no longer than one year from the date of signature or until records are processed.

____ _______________
Signature of Patient Printed Name Date

____ _______________
Signature of Authorized Person Printed Name & Relationship Date