EYE CARE CENTER OF LAKE COUNTY, LTD.
310 S. Greenleaf Street
Suite 209
Gurnee, IL 60031- 5708
Phone: 847-244-1657
Fax: 847-244-5122

AUTHORIZATION TO RELEASE PROTECTIVE HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____ SSN: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME PHONE: ( ) _____ ALTERNATIVE NUMBER: ( ) _____

I, hereby authorize release of health information for ☐ myself or ☐ dependent minor to be released from Eye Care Center of Lake County, Ltd to:

NAME OF PHYSICIAN/PRACTICE: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PHONE: ( ) _____ FAX NUMBER: ( ) _____

☐ I authorize you to release medical records dating from _____/_____/_____ to _____/_____/_____

☐ I authorize you to release a copy of eye glass or contact prescription dated: _____/_____/_____

Reason for request to release medical records (**THIS SECTION MUST BE COMPLETED**)

☐ insurance change ☐ insurance/claim processing ☐ other: _____

☐ seeking second opinion ☐ continuity of medical ☐ transferring out of practice _____
Reason

The above named person has the following rights: This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form. A copy of the form is a valid as the original document.

- This authorization will expire **90** days from the date signed. Additionally, you may revoke this authorization at any time by submitting a written request to Eye Care Center of Lake County. Your revocation will be honored except to the extent that has been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be released. This and other specific rights regarding the handling of your health information are outline in our Privacy Practices document.
- The information you are authorizing to be release could be re-released or disclosed by the recipient, such additional disclosures or releases may not be prohibited by law. We are not responsible for actions of others who may be provided your information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits.

Signature: _____ Date _____

☐ Self ☐ Authorized Representative (print name) _____ Relationship: _____

There may be a fee associated with the copying of your records. Please contact our business office for additional information about applicable copying fees. Please note that we have 30 days to process your request for medical records that we have on premises, if your records are at a storage facility we have up to 60 days to process your request. All request for medical records require a written authorization. Unless urgent, all records will need to be picked up in person or will be mailed to your new provider.