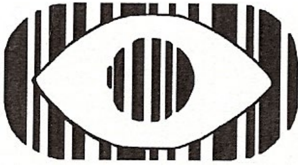

Eye Physicians & Surgeons, S.C.

1311 S. Lincoln St. Elkhorn, WI 53121 | Phone: (262) 723-4600
675 W. State St. Burlington, WI 53105 | Phone: (262) 763-7772
Fax: (262) 947-4996 | Website: https://eyephysician.com

DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Full Name of Patient: ______________________________

Date of Birth: ____________ Address: ______________________________

I authorize and request *Eye Physicians & Surgeons, S.C.* to: (check only one)
Disclose information to: Obtain information from:

Name (or title) and organization______________________________

Address ______________________________

City ______________ State ____________ Zip____________

Phone ______________ Fax ______________

☐Eye Physicians & Surgeons 1311 S. Lincoln St. Elkhorn, WI 53121 P: 262-723-4600

☐Eye Physicians & Surgeons 675 W. State St. Burlington, WI 53105 P: 262-763-7772

Information to be released by: Mail Pick up Fax

Disclose the following:
All of my health information for further medical treatment.
Special Tests: ______________________
Other: ______________________

Purpose of disclosure:

☐ Continuing Medical Care	☐ Relocating	☐ Physician Change
☐ Legal Matter	☐ Insurance Change	☐ Other

This authorization ends on: ______________ (If not specified expires 1 year from date of signature)

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
I understand that uses and disclosures already made based upon my original permission cannot be taken back.
I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

By checking this box, you agree to use an electronic document and an electronic signature. You understand that electronic signatures are legally binding. Please type your name below.

Signature of Patient: ______________________________ Date: ____________

Verified with Medical Record Staff Initials: __________