AUTHORIZATION TO RELEASE MEDICAL INFORMATION

SCHOOL OF OPTOMETRY
INDIANA UNIVERSITY
Bloomington

IMPORTANT PLEASE READ: This form authorizes your health care provider to release health information regarding your care or treatment to the individual or organization you identify as set out below:

I hereby authorize IU School of Optometry to: **(check one)**

[ ] **Provide** records to: ____________________
Name and address of person or organization
____
____________________ ____________________
Phone Fax

[ ] **Obtain** records from the entity listed below:

Purpose of Request:

[ ] At request of Patient or Patient Representative

[ ] Other: ____________________

The medical records of:

Patient Name: ____________________
Last First Middle/Maiden

Address: ____________________
Street City State Zip

Date of Birth: ____________________ Telephone #: ____________________

Records to Be Released From: [ ] **Indiana University School of Optometry** [ ] **Entity Listed Below**

____
Name and address of the provider
____

Please release the following information: (please check minimum information needed to achieve purpose)

[ ] Eyeglasses Prescription
[ ] Contact Lens Information
[ ] Copy of Last Exam
[ ] BMV Application
[ ] School Report
[ ] Insurance Disability Form
[ ] Summary Report/Letter
[ ] Other (specify): ____________________

I understand this release may include disclosure of information relating to treatment for alcohol/substance abuse, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), sexually transmitted disease (STD), or for psychiatric treatment or counseling, unless I specify otherwise below:

Please do not release any information concerning treatment for the following: ____________________

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN BASED UPON IT. <u>THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS</u> FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED: ____________________

Information used or disclosed because of this authorization may be further disclosed by the recipient and therefore no longer protected.

Date: __________ Signature: ____________________
Patient

Signature: ____________________ / __________
Parent/Guardian Relationship

If Patient Unable to Sign: ____________________ / __________
Witness Reason

IUSO may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization except as allowed under the HIPAA regulations

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Released by Date