CONSENT TO RELEASE OF INFORMATION

Ries Eyecare
2213 Okoboji Ave.
Milford, IA 51351-1275
Phone: 712.338.7000 Fax: 888.972.4811

Patient's Legal Name: _____ Birth Date: _____

By signing this form, I am allowing Ries Eyecare to ____ release or ____ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named patient with the following individual or agency:

_____
Name of Person and/or Institution

_____ _____ _____ _____ (___)_____ (___)_____
Address City State Zip Phone # Fax #

Check the information to be disclosed:

_____ Medication List
_____ ROS, Medical and Sx Hx
_____ Last Exam
_____ All Exams
_____ Photos, OCTs, VFs, and other tests
_____ Other: Please Specify _____
_____ CL RX
_____ Spectacle RX

Please indicate the reason for release:

_____ Continuity of Care
_____ Transferring Care
_____ Other: Please Specify _____

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to: Ries Eyecare, 2213 Okoboji Ave. Milford, IA 51351. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Ries Eyecare at the above address.

This agreement will expire one year from the date of signature, or on date specified: _____

_____ _____
Patient Signature Date

_____ _____ _____
Legal Guardian Signature Date Relationship

Office Use Only:
Please send records: _____
Please request records: _____
Date records/request was sent and by whom: _____
Description of records sent: _____