Patient First Name Middle Last

Guardian or Authorized Party Name (if applicable)

___ ___ ___ - ___ ___ - ___ ___ ___ ___
Social Security Number

___ ___ / ___ ___ / ___ ___ ___ ___
Date of Birth

I authorize the use and disclosure of my health information as described below:

Information Requested:

☐ Records relating to treatment dates including visual fields from ___ ___ / ___ ___ / ___ ___ to ___ ___ / ___ ___ / ___ ___

☐ Records for all care at this facility or by this doctor.

☐ Other (please specify) ____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire in 90 days from today's date.

Information to be released: **To** Willcockson Eye Associates, P.C.
PO Box 819
Yankton, SD 57078-0819
(605) 665-9638
Fax: (605) 665-0526

From ____

____

____

____

____
Signature of Patient or Guardian **

___ ___ / ___ ___ / ___ ___
Date

A fax copy or photocopy of this consent shall be as valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions, I DO ____ DO NOT ____ authorize the release of this information.

** If this authorization is signed by an individual's personal representative, the representative's authority is based on:

(e.g. state law, court order, power of attorney, etc.) ____