Willcockson Eye Associates, P.C. Medical Records Request

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.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Information to be released: **To** _____

_____

_____

_____

From Willcockson Eye Associates, P.C.
PO Box 819
Yankton, SD 57078-0819
(605) 665-9638
Fax: (605) 665-0526

_____ ___ ___ / ___ ___ / ___ ___
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.) _____

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee is $15.00 which includes up to ten pages plus $0.30 per page for each additional page over ten. No fee shall be charged for reproducing and forwarding records directly to other physicians.

For office use only:
Physician Authorization _____ Date sent: ___ ___ / ___ ___ / ___ ___ By:_____