p: 763-757-7000

f: 763-757-3328

a: 12170 Aberdeen St NE Blaine, MN 55449

w: www.BlaineEyeClinic.com

e: MedicalRecords@blaineeyeclinic.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: ___________________ Patient Name: ____

Date of Birth: ___________________ Telephone #: ____

Patient Address:____

☐ **Authorization to Transfer Records to Blaine Eye Clinic.**
I am requesting that my health care information be transferred to Blaine Eye Clinic.

☐ **Authorization to Transfer Records from Blaine Eye Clinic to another clinic or self.**
I request Blaine Eye Clinic to transfer my health care information designated below to the following:

Release to/from: Name____

Address ____

City/State/Zip ____

Reason for transfer: ____

I am requesting release of the following records:

☐ All Clinical Records

☐ Clinical Records only related to ____

☐ Visual Fields

☐ Fundus Photography and/or Retinal Imaging

This authorization is limited to the following dates: From: ___________________ To: ____________________

This authorization may be revoked at any time. If revoked, no actions already taken by Blaine Eye Clinic, based upon this authorization will be affected. I understand that once my protected health information is disclosed, the entity which receives it may re-disclose it, and privacy laws may no longer protect it. Unless revoked earlier this authorization will expire 90 days after the date it is signed for or shall remain in effect for the period reasonably needed to complete the request. I understand that Blaine Eye Clinic will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

Patient's signature: ____Date:_____/_____/_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Signature of authorized representative: ______________________________________Date:_____/_____/_____

Print Name and relationship to patient: ____

Source of Authority: ____

Today’s Advanced Care. Yesterday’s Personal Attention.