Fox Valley Ophthalmology

40W330 LaFox Rd. Suite A
St. Charles , IL 60175
Ph. (630) 584-9850
Fax. (847)324-2212
Mail@foxvalleyeyes.com

Authorization For Use or Disclosure Of Protected Health Information (PHI)

Requested For: **_____** ***Date of Birth:*** **____/_____/_____**

Information to be released:

_____Entire Chart Record

_____Only from **_____/_____To _____/_____** _____Exam Notes ____Testing

___ I hereby authorize my medical records to be released to:

Fox Valley Ophthalmology

___ I hereby authorize Fox Valley Ophthalmology to release my medical records to:

Doctor/Recipient Name: _____

Address: _____

City/State/Zip: _____

____Mail to above OR Fax to: (_____) _____-_____

PATIENT SIGNATURE: _____Date: _____

(Parent/Guardian if patient is a minor, or Power of Attorney if applicable)

Fox Valley Ophthalmology's Notice of Privacy Practices provides information about how we may use and disclose protected health care information (PHI) about you in order to provide treatment, receive payment, and carry our health care operations. This form gives us permission to share information with another physician or health care practice or for them to share information with us. By signing this form, you authorize Fox Valley Ophthalmology to use and disclose Protected Health Information about you as indicated above. You have the right to revoke this authorization at any time, if provided in writing and signed by you or your legal representative. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Your revocation must be submitted to the Privacy Officer of our Practice.

THIS RELEASE WILL AUTOMATICALLY EXPIRE IN 90 DAYS. 02/22

Fox Valley Ophthalmology

40W330 LaFox Rd. Suite A
St. Charles , IL 60175
Ph. (630) 584-9850
Fax. (847)324-2212
Mail@foxvalleyeyes.com