SPECTRUM EYE INSTITUTE
963 N. 129 INFANTRY DRIVE
SUITE #110
JOLIET, IL 60435-3170
(815)729-3777 (OFFICE) (815)725-9373 (FAX)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Reason for request:_____

Patient name:_____ Date of birth:_____

Address:_____

Phone:_____ SS#_____

I authorize (name of previous doctor):_____

Address:_____

Phone:_____ Fax:_____

To release medical information from my medical record and send it to:

Name of new physician:_____

Address:_____

Phone:_____Fax:_____

I authorize you to release my entire record to the physician names above subject to the Following limitations, if any:

_____No limitations or (check any of the following)
_____Only information related to the following:
_____HIV/AIDS
_____Mental Health
_____Substance Abuse
_____Any medical record from other physicians or providers

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed_____Date:_____
If not patient, state relationship

For Office use only
Received_____ Completed by_____

Completion date:_____ Release consisted of:_____

_____

Other notes:_____