Ophthalmology Associates & LASIK Center of Mankato, P.A.
1630 Adams Street
Mankato, MN 56001
507-345-6151 OR 888-605-5189 FAX 507-625-1096

Emily Birkholz, M.D. / Seth Consoer, M.D. / Gerald Roust, M.D./John Hoines, MD

AUTHORIZATION FOR RELEASE OF INFORMATION

1. PATIENT:____ BIRTHDATE:________________________

   ADDRESS:____PHONE:_______________________

I authorize:______________________________________ (Physician and/or Facility)	To release to:______________________________________ (Physician and/or Facility)
Address:____	Address:____
City, State, Zip:________________________________	City, State, Zip:________________________________
Phone/Fax:______________________________________	Phone/Fax:______________________________________

2. Information Requested:
   Medical Records Regarding:_______________________________ during____________________________________
   (Medical conditions) (Dates of service)

3. Needed for appointment date of:____

4. I understand Ophthalmology Associates may not condition treatment on my signing this authorization and I have the right to refuse to sign this authorization. ___________ (Initials of patient/Guardian)

I understand 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 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 send it to: OPHTHALMOLOGY ASSOCIATES & LASIK CENTER, 1630 ADAMS STREET, MANKATO, MN 56001.

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

I authorize release of my medical records in accordance with the specifications listed above. I understand this authorization is good for **one year from this date** unless written notification is given.

Authorizing Signature:____ Date:_______________________

Relationship to patient if signed by guardian:____

Signature of Witness:____

If an authorization is signed by an individual's personal representative, the representative's authority is based on:
____ (e.g., state law, court order, etc.)

Spouses or parents of children 18 years of age or older cannot request and/or sign for patient unless he/she is incapacitated or deceased.
A photocopy of this authorization shall be considered as valid as the original.
Note to Patient: This form is required to comply with the HIPAA Regulations. You must always contact our office in person to update this release form. Contact by phone or fax is not acceptable.