The difference is in sight.

PROFESSIONAL SOLUTIONS FOR CATARACTS, GLAUCOMA & CORNEA

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

______________________________	______________________________
Patient name	Date of birth
______________________________	______________________________
Street address	City, State, ZIP

I authorize: To disclose/To obtain my protected health information (as described below) To/From:

Tower Clock Eye Center	______________________________
Name	Name
1087 West Mason Street	______________________________
Address	Address
Green Bay, WI 54303	______________________________
City, State, ZIP	City, State, ZIP

Information to be released:

_____Medical history, examination, reports _____Prescriptions _____Hospital reports
_____Surgical reports _____Consultations
_____Other: ____

Purpose for Need of Disclosure: _____Continuing care _____Insurance
_____Transfer of care _____Personal _____Legal

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal standards and my health information might be re-disclosed without my authorization.
I understand I have the right to:

- Receive a copy of this authorization
- Refuse to sign this authorization and that treatment, payment enrollment in a health plan or eligibility benefits may not be contingent on my signing this authorization.
- Revoke this authorization, except to the extent that the person(s) and organization(s) listed above made in reference to this authorization.

This authorization will remain in effect until (one year of date signed) _______________ or event ________

______________________________	______________________________
Signature of patient (or legal representative)	Date
______________________________	______________________________
Relationship to patient	Date

This release is executed in conformity with Wisconsin Stats §§146.81-83, 252.15 Revised 2/12/20