Authorization to Disclose Health Information

By completing this form, you allow Tower Clock Surgery Center to disclose health care information to the individuals you identify.

SECTION 1: Name of Patient

Name _____ DOB _____/_____/_____

SECTION 2: Identify the person or entity that is <u>to receive</u> the information:

Name _____ Relationship to You_____

Name _____ Relationship to You_____

Name _____ Relationship to You_____

SECTION 3: Identify what health information may be released:

- ☐ All Information.
- ☐ All Health Information Except: _____
- ☐ Billing and Payment Information Only
- ☐ Appointment Information Only

SECTION 4: Identify how long you would like this authorization to last:

This authorization shall be in force and effect until revoked by the undersigned, in the manner described below or until (insert expiration date or event) _____(whichever is shorter).

SECTION 5: Your Rights:

You have a right to request a copy of this form and to request a copy of the information that is being disclosed. You have a right to revoke this authorization at any time by sending written notice to:
Tower Clock Surgery Center, 1077 West Mason Street, Green Bay, WI 54303. Revoking this authorization will not have any effect on actions that Tower Clock Eye Center takes prior to receiving the notice of revocation. The information disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws.

_____ _____

Signature of the Individual or Individual's Legally Authorized Representative * Date

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** NOTE: If you are signing as the member's Legally Authorized Representative, attach a copy of the appropriate document(s) granting you the authority to do so. Examples would be a health care power of attorney, a court order, guardianship papers, etc.*