TOWER CLOCK
EYE CENTER

The difference is in sight.

Professional Solutions for Cataracts, Glaucoma & Cornea

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

_____ _____
Patient Name Patient Date of Birth

_____ _____
Patient Street Address City, State, ZIP Code

☐ I wish to release records from Tower Clock Eye Center to:

-OR-

☐ I wish to request records released to Tower Clock Eye Center from:

Clinic/Doctor: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

Information to be released:

☐ Medical history, examination, reports ☐ Prescriptions ☐ Hospital Reports
☐ Surgical Reports ☐ Consultations
☐ Other: _____

Purpose for Need of Disclosure:

☐ Transfer of Care ☐ Continuation of Care ☐ Insurance
☐ 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 a 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 signed date) _____ or event: _____.

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

This release is executed in conformity with Wisconsin Stats §§146.81-83, 252.15

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