MILWAUKEE AVENUE
EYE CENTER

7421 N. Milwaukee Avenue
Niles, IL 60714
P: (773) 775-0811
F: (773) 819-7013

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: ____ Date of Birth:_______________

Address: ____ City _____________ State ____ Zip________

Records for date(s) ____________________ to________________ or ☐ ALL RECORDS

Purpose of need for information:

____

I hereby authorize that the protected health information regarding the above named person be forwarded.

FROM:

Person/Institution: Milwaukee Avenue Eye Center Phone: (773) 775-0811

Address: 7421 N. Milwaukee Avenue
Niles, IL 60714

TO:

Person/Institution: ____ Phone: __________________

Address: ____

City: _______________________________________ State: _________ ZIP: ___________

Preferred Delivery method:

☐ Fax
Fax #:_____________

☐ Mail
Address: ___________________________

☐ Email
Email: _________________

Patient Signature ____ Date: ___________________

Guardian Signature ____ Date: __________________

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medial record contact person at this site of care except that action has already been taken to release the information. This Authorization shall remain valid unless revoked but will expire in one year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse.

A $20 record copying fee will be charged for records exceeding the last visit.

This form must be completed and signed and payment must be made prior to medical records being released.