Office Use: PT ID # _____

Brenart Eye Clinic
120 E. Countryside Pkwy
Yorkville, IL 60560
Phone: 630-553-6166 Fax: 844-351-2564

Authorization for Release of Identifying Health Information

Patient Name: _____ DOB: _____

Patient Address: _____Phone: _____

I authorize the professional office of my eye professional named above to release/obtain the health information of the above named person identifying me (including if applicable) information about HIV infection or AIDS, information about substance abuse treatments and information about mental health services under the following terms and conditions.

1. Detailed description of the information to be released: _____
2. The purpose for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose if desired by the individual).
3. Expiration date or event relating to the individual or purpose for the release. One year from date of signing.
4. From/To: _____
   Address: _____
   Fax #: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you decline to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

I have read and understand this form. I am signing it voluntarily. I authorized the disclosure of my health information as described in this form.

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.
Relationship to Patient: _____ Print Name: _____

Source of Authority: _____