McCannel Eye Clinic

3100 West 70th Street

Edina, MN 55435

Phone (952) 848-8300 / Fax (952) 848-8315

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient name: ____________________________ DOB: _______________

Address: ____

Phone: __________________________ Cell: _________________________

I authorize McCannel Eye Clinic to request my medical records FROM:

____

____

I authorize McCannel Eye Clinic to release my medical records TO:

____

____

The following information is to be released (check appropriate boxes):

- ☐ Office notes
- ☐ Lab tests
- ☐ Other: ____

For the following dates of treatment:
From: __________________________ To: __________________________

I am requesting this information be released for the following reason:

- ☐ Continuation of care
- ☐ Attorney review
- ☐ Personal use (please enclose $1.34 per page payment; $20 max.)
- ☐ Other: ____

- ❖ I understand that once information is released pursuant to this authorization, McCannel Eye Clinic cannot prevent the re-disclosure of this information to another third party.
- ❖ Except for research related treatment, McCannel Eye Clinic will not condition treatment on my signing of this authorization.
- ❖ I understand there may be a retrieval and copy charge associated with this release.

I understand that I may revoke this authorization by sending a written request for revocation to: Angie Madison, 3100 West 70th Street, Edina, MN 55435. If I revoke this authorization, McCannel Eye Clinic will no longer use or disclose my information for the reasons covered by this authorization except to the extent it has already relied upon this authorization.

This authorization shall expire one year from the date signed.

I understand and agree to the terms of this authorization:

____

Patient or patient representative signature

____

Date

If signed by a patient representative, state authority to act on behalf of the patient:

____