

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**FROM WHEATON EYE CLINIC**

**Patient Information (Please print)**

Zip:

State:

E-mail (optional):

City:

Phone:

Street Address:

Date of Birth (MM/DD/YYYY):

Name at Time of Treatment (if different from above):

First Name: Middle Initial: Last Name:

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**Please check all items requested:**

Time period of records to be released: Entire Chart Records Only from: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ through \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Exam Notes Testing Operative Reports **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Purpose of request:**

Future treatment Personal records Insurance Legal Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How would you like your records delivered? (Please Note: We are unable to e-mail records at this time)**

Mail Paper OR CD

Fax

**Where do you want the information sent? (Fill in boxes below**):

WHEATON EYE CLINIC should provide my records to: Self Personal Representative (indicated below)

Recipient Fax (if applicable):

Recipient Mailing Address:

Recipient Phone:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recipient Name:

**Please print your name and sign below**:

**Relationship (please print)**

**Signature of Patient or Legal Representative**

**Date/Time**

**Name of Patient or Legal Representative (please print)**

**Please return completed form to:** Medical Information Department – Wheaton Eye Clinic records@wheatoneye.net

2015 N. Main Street, Wheaton IL 60187 • Telephone: (630) 588-3703 • Fax: (630) 668-8976 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

WHEATON EYE CLINIC *recognizes a patient’s right under HIPAA to access copies of his/her health information. There may be a charge associated with processing a request and producing requested records.*

I have read and agree to the statements on the back side of this form. \_\_\_\_\_\_\_\_\_ Initial.

This authorization shall be in force and effect for the specified purpose for one (1) year from date signed at which time this authorization to use or disclose this Protected Health Information expires.

It is my understanding that:

* I may revoke this authorization at any time by sending written notification to: Attn: Health Information, Wheaton Eye Clinic, 2015 N. Main St., Wheaton IL 60187.
* Such revocation will not be effective to the extent that Wheaton Eye Clinic has used or disclosed your specified Protected Health Information (PHI) in reliance on this authorization.
* The Wheaton Eye Clinic may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization, except that Wheaton Eye Clinic may condition the provision of research-related treatment on my provision of an authorization for the use or disclosure of Protected Health Information for such research.
* Information used or disclosed pursuant to this authorization (excluding certain defined categories) may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”).
* I further understand that I may be provided a copy of this signed Authorization at my request.

**WHEATON EYE CLINIC**

**POLICY FOR COPYING PATIENT RECORDS**

Dear Patient:

For paper copies, Wheaton Eye Clinic established the following policy to cover the costs of photocopying patient records.

 Last three patient visits: No charge

 If you would like a paper copy of your entire chart, we charge as permitted by Illinois State law 735 ILCS 5/8-2006.

 Pages 1 – 25 $1.18 per page

 Pages 26 – 50 $0.79 per page

 All pages over 50 $0.39 per page

If you are requesting more than your last three visits, you will be notified of the amount owed before your chart is photocopied. As soon as your check is received, your chart will be copied as requested. Please send your check to the Wheaton office, Attention: Medical Records.

For an electronic copy, Wheaton Eye Clinic charges a flat fee as permitted by the HITECH Act for any and all records requested:

 HITECH flat fee $6.50

You will be notified of the amount owed before your chart is electronically copied. As soon as your check is received, your chart will be copied as requested. Please send your check to the Wheaton office, Attention: Medical Records.

Please be advised fees listed here are only for records provided to the patient or the patient’s personal representative.

Sincerely,

Health Information Management Team