

Iowa Eye, P.C.
Michael A. Hall, M.D.
Steven J. Jacobs, M.D.
Jeffrey L. Maassen, M.D.
David Muller, M.D.
David E. Puk, M.D.
Sanjay S. Shah, M.D.
Alex G. Smith, M.D.


IOWA EYE CENTER
1650 First Avenue, N.E.
Cedar Rapids, Iowa 52402
319-362-EYES (3937)
Fax 319-362-2900

AUTHORIZATION TO OBTAIN INFORMATION

Name _____

Information Sent For _____

Date of Birth _____

Chart Number _____

Date

I, the undersigned, hereby authorize Iowa Eye Center to obtain from

(name of person or institution)

(address)

a copy of the clinical notes pertaining to my evaluation and treatment and copies of the following information as indicated (if additional information is necessary):

_____ History	_____ X-ray Reports
_____ Physical	_____ Laboratory Reports
_____ Problem List	_____ Ophthalmic Information
_____ Medication List	_____ Other information as indicated
_____	_____

I understand that I may revoke this consent at any time by sending a written notice to _____
_____. I understand that any release which has been made prior to my revocation and which was made in this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting Iowa Eye Center.

This authorization will automatically expire sixty (60) days from the date of signature, except as specified: _____
At that time, no express revocation shall (specify number of days/months) be needed to terminate my consent.

SPECIFIC AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION AND/OR DRUG/ALCOHOL ABUSE INFORMATION

X _____
Signed Date

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law and that address is applicable to EITHER mental information or Drug/Alcohol Abuse or BOTH. My signature authorizes release of all such information (as specified above).

Address

X _____
Signature Date

Witness

In order for the above information to be released, you must sign here and to the right.

Relationship