WHEATON
EYE CLINIC

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM WHEATON EYE CLINIC

Patient Information (Please print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different from above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

Please check all items requested:

Time period of records to be released: ☐ Last three visits ☐ 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?

☐ Mail ⟶ ☐ Paper OR ☐ email **(Last three visits only)**

☐ 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 Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax (if applicable):

Please print your name and sign below:

Name of Patient or Legal Representative (please print)	**Relationship (please print)**
Signature of Patient or Legal Representative	**Date/Time**

Please return completed form to: Medical Information Department – Wheaton Eye Clinic **records@wheatoneye.com**
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	$1.30 per page
Pages 26 – 50	$0.87 per page
All pages over 50	$0.43 per page

If you request 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.

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 note that the fees listed here are only for records provided to the patient or the patient's representative.

Sincerely,

Health Information Management Team