WHEATON
EYE CLINIC

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO 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:

I am authorizing _____ to release records
(Previous Physician Name)

Address*: _____ Phone: _____
It is important to be specific with the address/phone/fax number of Previous Physician
Fax: _____

Please check all items requested:

Time period of records to be released: Only from: ____/____ / ____ through ____ / ____ / ____

☐ Exam Notes ☐ Testing ☐ Operative Reports ☐ Photographs

Please print your name and sign below:

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

Please return completed form to: Medical Information Department – Wheaton Eye Clinic
2015 N. Main Street, Wheaton IL 60187 • Telephone: (630) 588-3703 • Fax: (630) 668-8976
Email: records@wheatoneye.com