VISION SOURCE®
YANKEE EYE CLINIC
1340 Duckwood Drive Ste. 14
Eagan, MN 55123
PH: (651) 452-0344
F: (651) 452-1564
visionsource-yankee.com

VISION SOURCE®
ROSEMOUNT EYE CLINIC
15083 Crestone Avenue
Rosemount, MN 55068
PH: (651) 423-3300
F: (651) 423-5252
visionsource-rosemount.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Sara Mitchell, Privacy Officer

Patient Name (print): _____
Patient Date of Birth: _____
Patient Address: _____
Patient Phone Number: _____

I authorize Rosemount Eye Clinic to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions:

1. Description of information disclosed:
   - ☐ All information
   - ☐ Personal Health Information
   - ☐ Insurance
   - ☐ Billing
   - ☐ Materials
   - ☐ Other: _____

2. Specific individual information disclosed to:
   - ☐ Spouse: _____
   - ☐ Parent: _____
   - ☐ Guardian: _____
   - ☐ Other: _____

3. The expiration date of the disclosure is 12 months from signature date unless otherwise specified here (must be 12 months or less by state law): ____/____/____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, fax, or e-mail the Privacy Officer noted in the *Notice of Privacy Practices*.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Time: _____ a.m./p.m. Date: ____/____/____

Patient signature: _____
OR Legally authorized representative's printed name: _____
Representative's relationship to patient (circle one): Parent Guardian Other: _____
Legally authorized representative's signature: _____