**MEDICAL INFORMATION RELEASE FORM**

**HIPAA RELEASE FORM**

SPEARFISH EYE CARE CENTER

DR. MICHAEL S. RICHEY

DR. KATHY HAIVALA

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (**PATIENT’S NAME)** (**PATIENT’S DATE OF BIRTH)**

⃝ I authorize the release of all examination information and financial information to the

 following:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: ⃝ Spouse ⃝ Child ⃝ Other

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: ⃝ Spouse ⃝ Child ⃝ Other

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: ⃝ Spouse ⃝ Child ⃝ Other

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: ⃝ Spouse ⃝ Child ⃝ Other

**OR:**

⃝ I do not authorize the release of any exam/financial information.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

In the course of providing service to you we create, receive and store information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail.

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Signature

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

Date

This Release of Information will remain in effect for five years unless terminated by me in writing.