Ophthamlology, PC
300 N. Grandview Ave.
Dubuque, IA 52001-6397
Phone: (563) 588-4675
Fax: (877) 241-4588

Bryan P. Pechous, MD
Lucas S. Flamich, OD

Authorization for Release of Confidential Health Information

Patient Name: ____ Birth Date: __________________

Address: ____

Phone#: ___________________________ Cell#: _______________________________

Authorizes: Ophthalmology, PC
300 N. Grandview Ave.
Dubuque, IA 52001

□ All Medical Records from the last 3 years
□ Other:____________________________

To Disclose To:

____
Name of Recipient Phone Number Fax Number

____
Address of Recipient City State Zip

Reason for Release: □ Transferring Care □ Moving out of area □ 2nd Opinion □ Personal File
□ Coordination of Care □ Other:________________________

*****My appointment is scheduled: _____________________________**

I do NOT want any of the following information released:

___Mental health treatment records ___Drug abuse treatment records
___Alcoholism treatment records ___HIV/Acquired immunodeficiency syndrome (AIDS) records

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event that I refuse to authorize the release of the above described information. I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand that I may revoke this authorization at any time by giving written notice to my physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where my physician has already replied on it to use or disclose my health information. Written revocation must be sent to our office.
- This authorization for release of information will be valid for 1 year but only for medical information that was available on or before the date that this authorization was signed. A new, separate authorization will be required for release after the date this authorization was signed.

____
Signature of Patient or Legal Guardian Date

Relationship to Patient (Parent, Guardian, Power of Attorney, etc.)_____________________________________