Dr. Larry Vander Zee
Dr. Paul Greenfield
Dr. Jeannie Dehne

THE EYE DOCTORS, P.C.

5116 South Western Ave
Sioux Falls, SD 57108
605-338-7104
Fax 605-575-3880

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

MEDICAL RECORD RELEASE

PATIENT NAME: _____ DOB: ____ /____ / ____

☐ **AT MY REQUEST, I AUTHORIZE:**

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

☐ **AT MY REQUEST, I AUTHORIZE:**

The Eye Doctors, P.C.
5116 South Western Ave
Sioux Falls, SD 57108
(605) 338-7104
(605) 575-3880

TO DISCLOSE THE FOLLOWING INFORMATION:

☐ any and all of the medical records pertaining to the treatment of the individual

☐ other _____

☐ **TO MAKE THE DISCLOSURE TO:**

The Eye Doctors, P.C.
5116 South Western Ave
Sioux Falls, SD 57108
(605) 338-7104
(605) 575-3880

☐ **TO MAKE THE DISCLOSURE TO:**

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

I understand that I may revoke this authorization at any time by notifying the releasing organization in writing. Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below. I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

_____ _____ ____ / ____ / ____

Signature of patient/legal guardian *Relationship to patient/legal authority* *Date*