Date Received: _____
Date Processed: _____

HORNER EYE CARE, LTD.

10016 Main Street | Richmond, IL 60071 | Phone: 815-678-3937 | Fax: 815-678-3737

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Provider:

Patient:

Date of Birth: / /

I request and authorize [Authorized individual] to release healthcare information of the patient named above to: ❑Myself ❑Other Person

Release healthcare information to:

Name:

Address:

Phone ( ) Fax ( )

Select delivery method ❑ eDelivery (secure web link) ❑ Fax ❑ US Mail ❑ Certified Overnight Delivery ($10 charge)

This request and authorization applies to:

❑ All healthcare information ❑ Billing ❑Other _____

❑ Healthcare information relating to the following treatment or condition _____

From Dates of Service: *(start date)* ___/___/___ to *(end date)* ___/___/___

Purpose of release to other person ❑ Continuation of Care ❑ Legal ❑ Insurance Company ❑ Work Compensation

Revoking (cancelling) authorizations: I may revoke (cancel) this authorization at any time. Revocations must be made in writing and will not apply to information that already has been released. Once information has been disclosed we can no longer protect it from further disclosure.

I understand that:

- I am not required to sign this authorization.
- My health care or payment for care will not be affected by my refusal to sign.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.
- **This authorization expires NINETY DAYS after it is signed.**

x _____ ___/___/___

Signature of Patient or Legal Representative (if patient is a minor or unable to sign) **Date** (mm/dd/year)

x _____

Printed Name of Legal Representative (if patient is a minor or unable to sign)

Relationship to Patient: ❑ Spouse ❑ Parent ❑ Next-of-Kin ❑ Legal Guardian ❑ DPOA for Healthcare