CONSENT TO RELEASE OF INFORMATION
Des Moines Eye Surgeons (DMES)

Please neatly PRINT (except signature) and provide complete information in each section.

Patient's Legal Name _____ **Birth Date** _____

By signing this form, I am allowing _____ to release medical information concerning the above named patient to:

_____
Name of person and/or institution who will receive information

_____
Mailing Address City, State, Zip

I would like this information to be shared by: Viewing____ Verbal____ Copies____ CD____
(Please note, burning to a CD is only possible when transferring electronic information. Copies of paper documents will be provided on paper.)

Check the information to be disclosed (include dates if known): ____Minimum necessary, or specify as follows:

____ Medication list ____Allergy list ____ Immunization record ____Problem List (Pt. Summary list)
____ History and Physical, specify clinic or date _____
____ Discharge summary, specify clinic or date _____
____ Laboratory results, specify type or date _____
____ X-ray and imaging reports, specify type or date _____
____ Consultation reports, specify doctor or clinic _____
____ Test results (e.g. EKG, PFT, etc.), specify type or date _____
____ Billing information, specify _____
____ Other, specify _____

Please check the reason for release below; and provide a date by which the info is needed: _____

Insurance_____ 2nd opinion _____ Rehab/disability _____ Personal file _____ Moving out of area _____ Legal _____

Other medical care _____ Transferring care_____ If transferring care, may we confidentially discuss with you? YES____ NO____

If yes, please indicate the best time and telephone number to reach you: _____

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to the Director of Health Information Management, at: _____. If this consent is cancelled, I understand that information may have been released prior to cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address.

Completion of this form is not required as a condition of evaluation or treatment. However, when the requested evaluation or treatment is **solely** for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services.

I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (***Initial*** any category ***not*** to be released).

Substance Abuse_____ Mental Health _____ HIV-related information_____ *Genetic tests/info _____

*Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This agreement will expire one year from the date of signature, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____ _____
Relationship, if Not the Patient Witness Signature