Koziol – Thoms Eye Associates
1211 S. Arlington Heights Road ● Arlington Heights ● Illinois ● 60005
P: 847.264.2222 ● F: 847.437-6841

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(Patient's Last Name) _____ (Patient's First Name) _____ (Date of Birth) _____

(Address) _____ (City) _____ (State) _____ (Zip Code) _____ (Phone) _____

Release of Records to:

(Name of Physician or Health Care Facility) _____ (Phone, Fax) _____

(Street Address) _____ (City, State, Zip) _____

For the purpose of:

[ ] Transfer of Care [ ] Legal [ ] Financial [ ] Personal [ ] Other_____

Information to be released:

[ ] All Records [ ] Office Notes [ ] Photos [ ] Visual Fields [ ] Other _____

By signing this form, I authorize **Koziol-Thoms Eye Associates** to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person or entity listed above.

(Signature of Patient or Authorized Party) _____ (Relationship to Patient) _____ (Date) _____

Notice of Confidentiality

This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Arlington Heights, IL 60005

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