Medical Information Release Form (HIPAA)

Name: _____ *Date of Birth:* _____

Release of Information

☐ I authorize Annandale Eye Clinic, Inc., and Cokato Eye Center, Inc. to discuss ALL ASPECTS of my protected health information including examination(s), test results, diagnoses, billing and claims information, status and dispensing of eyewear materials, and prescription information rendered to me with the individual(s) listed below:

Name: _____ *Relationship:* _____

Name: _____ *Relationship:* _____

☐ Information is not to be released to anyone.

Communications Regarding My Accounts

I authorize Annandale Eye Clinic, Inc., and Cokato Eye Center, Inc. to leave a detailed message and/or text regarding my account. Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts to any servicers and any debt collectors of my accounts ("Affiliates"), by various means, including, without limitation an automatic telephone dialing system, text message, email or an artificial or prerecorded voice, through any medium I provide to you, including, without limitation any cellular phone, landline, email address, fax number, text number or any other form of contact information I directly or indirectly provide to you or your Affiliates ("Contact Information").

Signed: _____ *Date:* _____

This Release of Information will remain in effect until terminated/changed by me in writing.

Annandale Eye
500 Elm St E,
Annandale, MN 55302
(320) 274-3701

Cokato Eye
115 Olsen Blvd #300,
Cokato, MN 55321
(320) 286-5695

Litchfield Eye
135 N Sibley Ave,
Litchfield, MN 55355
(320) 593-3100