ANNANDALE EYE | COKATO EYE | LITCHFIELD EYE

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

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call
- You may text me regarding account communications

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.