Boyce Family Eye Care, Ltd.
528 Devon Ave.
Park Ridge, IL 60068
847-518-0303
Fax: 847-518-0404

Today's Date___________

Patient Authorization for Boyce Family Eye Care, Ltd. To Release Protected Health Information

I authorize Boyce Family Eye Care, Ltd to release certain protected health information identifying me to

____
Name and address of entity to receive this information

This authorization permits Boyce Family Eye Care, Ltd. To release or disclose the following individually identifiable health information about me.

Information to be released:

- ☐ complete medical record
- ☐ summary of medical record
- ☐ notes of specific date of service _____
- ☐ other, please specify ________________

Purpose of the release of the health information:

- ☐ at my request
- ☐ research
- ☐ other, please specify ___________________________

This authorization will expire on:

- ☐ date, please specify _________
- ☐ at the end of the research study

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you or treat you any differently if you choose not to sign this authorization. You can also review your health information that we have before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how to see or get a copy of your health information (your medical record).

If you sign this authorization, you can revoke it later unless we have already released the information based upon this authorization. Revocation must be submitted in writing to the Boyce Family Eye Care, Ltd. at 528 Devon Avenue, Park Ridge, IL 60068.

When your health information is released as provided in this authorization, the recipient of your information often has no legal duty to protect its confidentiality. There is the potential that the recipient may re-release the information.

Print Patient's Name ____Birth date ___________________

Patient's address and phone____

Signature of Patient ____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient____________________________ Print Name _____________________________________

Source of authority ____

(You may be asked to provide documentation of this relationship to the patient.)

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION