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 Receive Protected Health Information

I authorize _____

(Name of Provider)

_____

(Address of Provider)

_____

(Phone Number)

To release certain protected health information identifying me to Boyce Family eye Care, Ltd. (Attention: Dr. Boyce). This authorization permits you to release or disclose the following individually identifiable health information about me.

It is completely your decision whether or not to sign this authorization form. A provider 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 before deciding whether to sign this authorization. A provider's 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 the information has already been released based upon this authorization. Revocation must be submitted in writing to the provider. 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.

Information to be released:	Purpose of the release of the health information:
☐ complete medical record	☐ at my request
☐ summary of medical record	☐ for my treatment
☐ notes of specific date of service_____	☐ other, please specify _____
☐ other, please specify _____	

This authorization will expire on: (Please specify date or event)

_____

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