Gregory E. Sutton, M.D.
Vincent J. Sutton, M.D.
Thomas A. Graul, M.D.
Matthew H. Wood, M.D.
Donald P. Sauberan, M.D.
Daniel A. Chruscicki, M.D.

Jordan J. Rixen, M.D.
David W. Blodgett, M.D.
Thomas J.E. Clark, M.D.
Samuel L. Thomsen, M.D.
Colby L. Argo, M.D.
Kaylyn R. Jackman, O.D.

RELEASE OF MEDICAL INFORMATION

_____ _____
Patient Name (Print) Medical Record Number Patient DOB

❒ Patient identification confirmed. **Staff signature:** _____

_____ I authorize **Eye Surgical Associates** to release my health information as described below.

To: _____

Address: _____

_____

Phone: _____ Fax: _____

-OR-

_____ I authorize the following provider:

Name: _____

Address: _____

_____

To release my health information as described below to :

Eye Surgical Associates
1710 S 70th St. Lincoln, NE 68506
Phone: 402-484-9000 Fax: 402-483-4223

Please release only the following information:

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

- ☐ Records from last _____years
- ☐ Dr. Letter only-Date_____
- ☐ OP Report Dates_____
- ☐ Diagnostic Reports_____
- ☐ Consultation reports (please supply doctors' names): _____
- ☐ Other (please describe): _____

The identified information will be used for the following purpose:

- ☐ My personal records
- ☐ Sharing with other health care providers as needed
- ☐ Other (please describe): _____

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-released by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to stop this authorization at any time. I understand if I stop this authorization, I must do so in writing to the practice. I understand the stopping this form will not apply to information that has already been released. I understand that stopping will not apply to my insurance company when the law provides my insurance company with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

_____ _____/_____/_____
Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

(This Authorization expires one year from date signed.)