Authorization To Use Or Disclose Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that, if the organization or persons authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name (please print): _____

Patient Address: (please print): _____

Date of Birth: _____

I hereby request and authorize _____ to release health care information to:

Dr. Stacy Symanski, Two Prudential Plaza, Chicago, IL 60601; Phone: 312.565.1600 **Fax: 844.272.6197**

Specific description of information to be used or disclosed:

X Chart Notes (All)
X Lab Reports (All)
X Procedure Reports (All)
X Contact Lens Prescriptions (All)

I understand that I will not be denied health care or health plan coverage, as the case may be, if I do not sign this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I receive a copy of this form after I sign it.

I understand that this authorization will **expire 60 days** from the date signed by me unless I revoke it earlier.

I understand that I may revoke this authorization at any time by notifying the person or organization providing the information in writing, and that if I do, it will not affect any actions taken before the revocation is received.

Signature of Patient or Patient's representative:

_____

Date:_____

Printed name of Patient's representative:

_____

Relationship of representative to Patient, if applicable:

_____