Send my records to Hedquist Eye Care

Directions:

In order to complete the records transfer request please fill out the following form including signature and date. You may email, fax, mail, or deliver to us via the following:

email admin@Hedquisteyecare.com

fax (712) 224-3939

mail Hedquist Eye Care
523 4th Street
Sioux City, IA 51101

or dropped off at our location and our staff will request the records transfer on your behalf.

We are sincerely grateful that you have chosen Hedquist Eye Care for your vision needs.

If you have any questions please call our office at (712) 224-3937.

Thank you,

The Hedquist Eye Care Team

HEDQUIST

EYE CARE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, patient undersigned below, authorize:

Hedquist Eye Care
523 4th Street
Sioux City, IA 51101
Telephone (712) 224-3937 Fax (712)224-3939
admin@hedquisteyecare.com

to release or obtain my medical/eye exam information, receipts of payment or balance due, and/or other information considered under the HIPAA privacy law to be part of the Designated Record Set to or from the following contact or entity:

Name of Office or Person I would like information from or to: _____ _____
Address: _____
City/State/Zip_____
Telephone # _____Fax # (if applicable) _____

Patient Information

Name: _____ Date of Birth:_____
Address: _____
Phone #: _____
Name of requestor if not patient: _____ *Relationship to patient:* _____

Purpose of Release: ☐ Continued Medical Care ☐ Insurance Claim ☐ Disability Determination
☐ Personal ☐ Other: _____

Hedquist Eye Care and the recipient designated above are released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Notice to Person or Agency receiving this information: This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. This authorization is effective for no longer than 1 year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it by giving written notice to Hedquist Eye Care. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Hedquist Eye Care. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand this authorization is voluntary. I understand that I am entitled to receive a copy of this completed authorization form.

_____ _____
Signature of patient or authorized representative Date Signed (required)