Wills Eye

Wills Eye Hospital Release of Information Authorization

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Patient Name:_____ Birth Date:_____

_____

Full Address: Street/City/State/Zip

_____ _____ _____

Telephone Number Social Security Number **(last 4 digits only** Medical Record Number

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This form authorizes_____

Person or class of persons authorized to make the disclosure

To use or to disclose to_____

Person or class of persons to whom we may make the disclosure with full address included

_____ _____

Telephone Number

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The following relevant and timely information (the exact information and format must be specified, e.g., verbal discussion, written reports, photographs, etc. and the dates or range of dates of treatment requested, if applicable

_____

_____

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I understand that information in response to this request may be related to testing of AIDS/HIV, whether the result is negative or positive and treatment for drug and alcohol use/abuse.

AIDS/HIV Information: Please initial here: _____Yes, Disclose _____ No, do not disclose
Drug or Alcohol use/abuse: Please initial here: _____Yes, Disclose _____ No, do not disclose

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This information is requested for the purpose of_____

This authorization Expires (insert date, event, or condition)
_____ If I fail to specify an expiration date, event or condition, this authorization will expire in 180 days.

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- You have been informed that you have the right to revoke this authorization at any time by written request made to the Privacy Officer at Wills Eye Institute, 840 Walnut Street, Philadelphia, PA 19107, Telephone number: 215-440-3150, except to the extent that action has been taken in reliance on this authorization.
- So long as this authorization does not relate to treatment to be provided to you at Wills Eye Institute, then you may refuse to sign this authorization without in any way affecting your treatment here.
- It is possible that information disclosed under this authorization might be disclosed by the recipient and no longer be protected.

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This form has been fully explained and I certify that I understand its contents.

Patient Signature_____ Date_____

Signature of Person Authorized in Lieu of Patient_____

Relationship to Patient_____

Witnessed by_____ Date_____

Records of deceased patients: If the requestor is not the executor of the decedents' estate then the requestor certifies by signing above that he/she is the next of kin responsible for the disposition of the decedent's remains.