

MEDICAL RECORDS RELEASE AUTHORIZATION

1. **Patient Name:** _____
Date of birth ____ / ____ / ____ Telephone Number (____) _____
Street Address _____
City _____ WI ____ Zip Code _____

2. **Persons and Organization authorized to disclose patient's health information:**
MARIA P. PATTERSON, M.D. Phone: (262) 641-8181
CHILDREN'S EYE CENTER FAX : (262) 641-8188
17000 W. NORTH AVE, SUITE 102E
BROOKFIELD, WI 53005

3. **Type of patient health information to be disclosed:**
☐ All Exam Records
☐ All Operative reports
☐ Visit date(s) of Health Information to be released _____

4. **Information to be disclosed to:**
Name of Health Care Provider and Facility OR Parent Name: _____

Street Address or Circle if same as above: SAME _____
Phone (____) _____
FAX (____) _____
City _____ WI ____ Zip Code _____

5. **Purpose of the disclosure:**
☐ Changing Physician
☐ Personal use
☐ Other _____

6. **PROHIBITION ON RE-DISCLOSURE: Federal and Wisconsin Confidentiality laws protect this information.**
Such laws prohibit the re-disclosure of such information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by such laws. However, I understand that the information disclosed may be potentially re-disclosed by the recipient and may no longer be protected by the federal privacy and confidentiality rules. I have had an opportunity to review and understand the content of this Authorization. I understand that this Authorization is voluntary. Maria P. Patterson, M.D. will not condition your treatment, payment, or eligibility for health care benefits based on my decision to sign this Authorization. I understand that I have the right to revoke this Authorization at any time. I can do so by submitting my revocation in writing. My revocation will not apply to information that has already been released in response to this Authorization.
By signing this Authorization, I am confirming that it accurately reflects my wishes.
A photocopy or facsimile of this Authorization is as valid as the original.

7. **Signature of Parent/Legal Guardian/Patient:** _____ **Date** ____ / ____ / ____
Print Full Name: _____
Authority/Relationship to Patient: _____ Self _____ Parent _____ Legal Guardian _____