MEDICAL RECORDS RELEASE AUTHORIZATION

CHILDREN'S EYE CENTER

Maria P. Patterson, M.D., S.C.
Pediatric Ophthalmology and Adult Strabismus

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:**
   Name of Health Care Provider and Facility_____
   _____
   Street Address _____
   Phone (____)_____
   FAX (____)_____
   City _____ WI ____ Zip Code _____

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

4. **Information to be disclosed to:**
   MARIA P. PATTERSON, M.D.
   CHILDREN'S EYE CENTER
   17000 W. NORTH AVE, SUITE 102E
   BROOKFIELD, WI 53005
   Phone: (262) 641- 8181
   FAX : (262) 641 - 8188

5. **Purpose of the disclosure:**
   - ☐ Changing Physician
   - ☐ Insurance eligibility/benefits
   - ☐ Moving
   - ☐ 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 Patient/Legal Guardian:** _____ **Date** ____/____/____
   Authority/Relationship to Patient: _____ Self _____ Parent _____ Legal Guardian