# AUTHORIZATION FOR THE DISCLOSURE OF PATIENT HEALTH INFORMATION

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 or Organizations authorized to disclose patient's health information:**

   Name of Health Care Provider ______________________________

   Street Address______________________________ Fax # (_____) ___________

   City ______________________________ WI ___ Zip Code ______________

3. **Type of patient health information to be disclosed:**

   ☐ All Records
   ☐ Operative reports
   ☐ Visit date(s) of PHI to be released ______________________________

4. **Information to be disclosed to:**

   **MARIA P. PATTERSON, M.D.**
   **CHILDREN'S EYE CENTER**
   **12690 W. NORTH AVENUE**
   **BROOKFIELD, WI 53005**

   **Phone: 262-641-8181**
   **Fax: 262-641-8188**

6. **Purpose of the disclosure:**

   ☐ Changing Physician
   ☐ Insurance eligibility/benefits
   ☐ Moving
   ☐ Personal use
   ☐ Other

7. **PROHIBITION ON RE-DISCLOSURE: Federal and Wisconsin Confidentiality laws protect this information.** Such laws prohibit the redisclosure 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 be redisclosed 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.

8. **Signature of Patient/Legal Guardian:** ______________________________ Date___/___/___

   Authority/Relationship to Patient: ___Self ___Parent ___Legal Guardian