AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Aurora EYE CLINIC, LTD.

1300 North Highland Avenue
Aurora, Illinois 60506

ROBERT J. BARNES, M.D.
Diseases & Surgery of the Eye
Glaucoma Specialty

ROBERT J. FOODY, M.D.
Diseases & Surgery of the Eye
General Ophthalmology

LISE ANNE GUAY-BHATIA, M.D.
Pediatric Ophthalmology
Adult Strabismus

LOIS A. POLATNICK, M.D.
General Ophthalmology
Neuro-Ophthalmology Specialty

RICHARD D. ZAK, M.D.
Diseases & Surgery of the
Retina and Vitreous

ALAN E. HEIN, O.D.
Optometrist

TERRI J. CLEVER
Office Management
Administration

Patient Information

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Date of Birth: _____
SS#: _____

I authorize the release of my medical records from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

To Be Sent To:
Aurora Eye Clinic, Ltd.,
1300 N. Highland Ave., Suite 1
Aurora, IL 60506
630-897-5104 phone 630-897-5089 fax

I understand that this authorization is valid only if the following questions are answered by me:

Specific Information to be released:

( ) **ALL MEDICAL RECORDS** without exception, including clinical notes, lab testing (including HIV), mental health treatment, alcohol or drug testing & treatment, sexually transmitted disease, consultations, secondary records, etc. or:

( ) **PARTIAL MEDICAL RECORDS** which may include HIV testing, mental health treatment, alcohol or drug testing & treatment, sexually transmitted disease & other sensitive information. Please specify parts and dates to be released.

( ) Office visits
( ) F.A.'s
( ) Photos
( ) Visual Fields
( ) Correspondence from/to other doctors
( ) Other _____

I understand that I may revoke this authorization to release information at any time by giving written notice. I understand that this authorization is valid 1 year from the date that it is signed.

This authorization may be relied upon when transmitted by facsimile:

_____ yes _____ no

2012 State Law provides that medical record fees are as follows:
($25.55 handling fee, not charged to patient)
Plus per page fees of are as follows:
.96 cents (pgs 1-25)
.64 cents (pgs 25-50)
.32 cents (over 51 pgs)
Plus actual postage cost per ILCS 5/8-2006 updated 2/2015

_____
Signature of Patient / Signature of Parent or Legal Guardian Date Signed