



Busby Eye Care
Kathleen I. Busby, O.D.
16409 Southpark Drive, Suite B
Westfield, IN 46074
Phone: 317-896-5005
Fax: 317-896-5335

Patient Information: Print name: _____ Date of Birth: _____

SS#: _____ Maiden or prior name: _____

Please release my healthcare information from:

Name of Facility/Provider: _____

Address: _____

City/State/Zip _____

Phone Number: _____

Please send my healthcare information to:

Name designated recipient: _____

Address: _____

City/State/Zip _____

Phone Number: _____

Information to be released

- The most recent 2 years of pertinent information (chart notes, and special tests)
- All medical records
- Specific information (please specify)

Purpose for which disclosure is being made:

- Sharing with other health care providers
- Legal investigation
- Other: _____
- Personal use
- I am transferring my care to a new health care provider

My Rights

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____

(Patient, Guardian, Authorized Representative)

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED