Kathleen I. Busby, O.D.
Nicholas Feipel, O.D.
Victoria Ray, 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: ___________Fax Number:___________

Please send my healthcare information to:

Name designated recipient:

____

Address: ____________________________________

City/State/Zip _______________________________

Phone Number: ___________Fax 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
- ☐ Personal use
- ☐ Legal investigation
- ☐ I am transferring my care to a new health care provider
- ☐ Other: ____

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 posed at the facility where your information is begin 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