Great River Eye Clinic
formerly Crosby Eye Clinic

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Ophthalmology
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Baxter, Minnesota 56425
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# Authorization to Use or Disclose Health Information

Fax to Great River Eye Clinic @ 218-546-5736

Patient Name: _____

DOB: _____

I authorize _____
*(location or clinic to get records from)*
to use or disclose my health information, as described below:

1. Description of health information that may be used and/or disclosed:

_____

_____

2. Name(s) of organization(s), person(s), or class of persons who may receive and use the information:

_____
*(location or clinic the records should be sent to)*

3. The purpose(s) for which the information will be used or disclosed:

_____

_____

4. I understand that I may revoke this authorization in writing at any time by sending a written request to the practice at the above address, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that information disclosed pursuant to this authorization potentially could be subject to re-disclosure by the recipient, and if re-disclosed the information would no longer be protected by the federal privacy rule. This authorization lasts for one year after the date you signed it unless you enter a different date or expiration here: _____

By signing below, I acknowledge that I have read and understand this authorization form.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

If signed by Patient's Representative, please print name and describe the representative's authority to act for the patient:

Representative's Name: _____

Representative's Authority: _____

_____

A COPY OF THIS SIGNED AUTHORIZATION IS AS GOOD AS AN ORIGINAL