2848 Niles Rd Saint Joseph, MI 49085 Phone: (269) 428-3300 Fax: (269) 428-5005	120 Longmeadow Village Dr Niles, MI 49120 Phone: (269) 684-6400 Fax: (269) 684-5103	570 Broadway St South Haven, MI 49090 Phone: (269) 637-3101 Fax: (269) 637-4000	3550 Park Pl W Ste 200 Mishawaka, IN 46545 Phone: (574) 222-1403 Fax: (574) 387-5464

GREAT LAKES EYE CARE

Toll Free 1-800-424-2393
www.greateyecare.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION OF:

The following will be completed by the patient or the patient's authorized representative		
Patient Name: (Please Print)	DOB	Telephone:

I hereby authorize: _____
Name of provider who is to release information

_____
Address of provider who is to release information

To release the following protected health information contained in my medical record regarding my care and/or treatment between the following dates: _____ to _____ to:

_____
Name of provider who is to receive information

_____
Address of provider who is to receive information — Fax number of provider receiving information

Authorization is for the use and disclosure of the following records: *(please indicate information to be released)*

☐ Doctor examination notes

☐ Other: (specify) _____

My authorization is given freely with the understanding that:

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- Great Lakes Eye Care may not condition my treatment on my provision of this authorization.
- A photocopy or fax of this authorization is as valid as the original.
- Great Lakes Eye Care, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- Upon my request I will be given a copy of this signed authorization if the authorization is at the request of Great Lakes Eye Care.
- This authorization is valid for one year or the following period of time: _____

_____
Signature of Patient or Legal Representative

_____
Date

_____
Printed Name of Above

_____
If the above signed is not the patient please indicate the relationship to the patient

For Great Lakes Eye Care use only	
REQUESTED □ Faxed □ Mailed Date: _____ Emp: _____	RELEASED □ Faxed □ Mailed □ Picked-up Date: _____ Emp: _____

Please return the completed form to any of our locations, email to medicalrecords@greateyecare.com, or fax to (269) 428-5005 *10/24 TC*