ANTIOCH EYE ASSOCIATES
AUTHORIZATION TO RELEASE INFORMATION

Patient's Name: First_______________ Middle _____________ Last__________________
Address: Street______________________ City______________ State______ Zip_______
Phone: Home_______________________ Cell ______________________
Date of Birth: ____________________ SS#_________________________

I authorize (referring provider) _________________________
Address: Street______________________ City______________ State______ Zip_______
Phone:_________________________ Fax:______________________

to release medical information from my medical record and send it to:
Antioch Eye Associates
Connie Crawford, O.D.,P.C.
Laura Cretors, O.D.
884 Hillside Ave.
Antioch, IL 60002
Phone: 847 395-4090 Fax: 847 395-7378

○ I authorize you to release my medical records dating from ________________to
____

○ I authorized you to release my entire record to the physician named above subject to the following limitations, if any.

_____ No limitations
OR (check any of the following)
_____ Only information related to the following is to be excluded:
- _____ HIV/AIDS
- _____ Mental Health
- _____ Substance Abuse

_____ Any medical record from other physicians or providers is to be excluded

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Purpose of release:________________________

Signed: ________________________ (patient) Date: ______________

Signed:_________________________ (witness) Date: ______________