Shopko Optical®

Release of Information (Informed Consent*)

Location Use Only

Date of Request:__________ Time of Request:__________________

IF PRIVACY OFFICE MUST PROCESS REQUEST, FAX TO 920-429-4444

Section A: Patient Information Please print clearly

Last Name First Name MI

ADDRESS CITY STATE ZIP

____/____/____
DATE OF BIRTH GENDER PHONE NUMBER

Section B: Records to be Released

I request the release of my complete healthcare record in the designated record set as checked below (subject to any checked exclusion(s)) for the following date range:

From: ____/____/____ To:____/____/____

- [ ] Eye exam record
  - [ ] Retinal camera photos
- [ ] Eyecare receipt
- [ ] Eyecare prescription

Please check to exclude:

- [ ] Mental health record
- [ ] Communicable disease (including HIV and AIDS)
- [ ] Alcohol/drug abuse treatment
- [ ] Other (please specify):____________________

Section C: Release Method

Records are to be released to: ______Patient ______Physician ______Other____________________

If to physician, please complete the following information:

NAME ADDRESS

PHONE NUMBER FAX NUMBER CITY STATE ZIP

Please indicate preferred method of delivery: Paper Record______ Electronic Record______ (PDF file via secure email)

Email Address:____________________

Section D: Purpose of Release

The purpose of this release of information is:

- [ ] For medical care
- [ ] An application for insurance
- [ ] Payment of insurance claim
- [ ] Personal use
- [ ] Housing authority eligibility
- [ ] Legal investigation or proceeding
- [ ] Disability determination
- [ ] Other ____________________

Section E: Duration of Release

This release is in effect through (not to exceed one year):______________unless rescinded by the patient in writing before that date or condition.

Section F: Signature

I authorize Shopko Optical to disclose the above medical information. The information disclosed pursuant to this Release may be redisclosed by the recipient and will no longer be protected by our Privacy Practices. I understand that signing this release is voluntary.

Patient Signature:______________________________ Date:__________

If person other than patient, please supply supporting documentation and complete the following:

Signature of person authorized by patient:______________________________ Date:__________

Relationship to patient:______________________________

The information contained in this document and the pages that follow is intended for the exclusive use of the addressee(s) and may contain confidential or privileged information. If you are not the intended recipient, please immediately notify the Privacy Office at Shoptikal LLC DBA Shopko Optical toll-free at 1-866-369-HIPA (4472) and destroy all copies and pages of this document.

*as defined by Wis. Stat. ch 146 Form HIPAA 0005-8 REV 9/19