Vision Source®

YANKEE EYE CLINIC
1340 Duckwood Drive
Eagan, MN 55123
PH: (651) 452-0344
F: (651) 454-1564

ROSEMOUNT EYE CLINIC
15083 Crestone Avenue
Rosemount, MN 55068
PH: (651) 423-3300
F: (651) 423-5252

CANNON EYE CLINIC
6487 Cedar Hills Drive
Cannon Falls, MN 55009
PH: (507) 263-3949
F: (507) 263-2295

Authorization for Release of Identifying Health Information
Sandy Willhite, Privacy Officer

Printed patient's legal name _____ D.O.B.: ____/____/____

Person-to-Person Communication

Please note, HIPAA regulations state we cannot release information to a spouse or parents of an individual over 18 without patient's consent. To help with my care or billing, Yankee/Rosemount/ Cannon Eye Clinic may share information with these people, including written communication. *If no one, please check 'No Information'.*

Please share: ☐ Scheduling Information ☐ Medical Information ☐ Billing Information
☐ No Information

_____	_____
First Name and Last Name	*Relationship to me*
_____	_____
First Name and Last Name	*Relationship to me*
_____	_____
First Name and Last Name	*Relationship to me*

I understand the following:

- Yankee/Rosemount/Cannon Eye Clinic will release all details to the person or persons above. This includes details about treatment for substance abuse, mental health conditions, and AIDS/HIV. If I don't want this information shared, I will write my initials here: _____
- This form does not have an end date. If I want to change the information on this form, I will fill out a new form. If I want to add or remove people for person-to-person communication, I will fill out another form. I may do so in writing, fax or e-mail to the Privacy Officer noted in the *Notice of Privacy Practices.*
- Once my information is shared with the person or persons named above, it may no longer be protected by privacy laws. Yankee/Rosemount/Cannon Eye Clinic cannot prevent these persons from sharing my information with a third party.
- If I do not sign this form, I will still be treated.

___/___/___ ___:_____ _____
Date *Time* *Signature of Patient or Authorized person*
(Authorized person should provide paperwork.)

Reason Patient is unable to sign: ☐ ***Minor*** ☐ ***Other:*** _____