JAMES E. MEMMEN, M.D.
GREEN APPLE EYE CARE

1543 Park Place Suite 400
Green Bay, WI 54304
Office 920-497-0100 Fax 920-497-0101

3232 North Ballard Road Suite 203
Appleton, WI 54911
Office 920-380-0100 Fax 920-380-0101

HEALTH INFORMATION DISCLOSURE AUTHORIZATION

____ ______________
Patient Name Date of Birth

____
Address, City, State, Zip

Obtain Previous Eye Care Records from:

____
Name of Previous Eye Care Provider

____
Address

Release Protected Health Information To:

James E. Memmen, M.D. Ltd
1543 Park Place Suite 400
Green Bay, WI 54304
Fax 920-497-0101

Information to be Used or Disclosed:

All Eye Care Records including all diagnostic tests
(Visual Field, OCT, GDX, Biometry / IOL Master, Etc.)

Other (specify) ____

Purpose for this Disclosure: (Check all applicable)

Further Medical Care / Changing Physicians

Legal Investigation or Action

At the request of individual

Insurance Eligibility / Benefits

Other (Specify) ____

Expiration Date of this Authorization: If not previously revoked, this content will terminate:

In one year

Upon request of the patient

I have had an opportunity to review and understand the content of this authorization form. I understand the completion and signing of this form authorizes the release of information to James E. Memmen, M.D. Ltd. (See back side of form)

____
Signature of Patient (or person legally authorized to sign for patient) **Date**

If other, indicate relationship:
Custodial Parent
Court Appointed Guardian
Health Care Agent
Personal Representative

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **Right to Refuse to Sign this Authorization:** I understand that I am under no obligation to sign this form. James E. Memmen, M.D. Ltd. may not condition treatment, payment, enrollment in a health plan or eligibility for the health care benefits on my decision to sign this authorization.
- **Right to Receive a Copy of this Authorization:** I understand that if I agree to sign this authorization, I may request a signed copy of said form.
- **Right to Withdraw this Authorization:** I understand that I can revoke this consent in writing, which will be effective upon receipt of James E. Memmen, M.D. Ltd. I understand that if I cancel this authorization, it will not affect uses and/or disclosures of my information that have already occurred based upon my authorization.

RE-DISCLOSURE: I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Note to the Patient and Recipient of Information: James E. Memmen, M.D. Ltd. reserves the right to assess a charge for labor and supplies for making photocopies. This disclosed information is protected under Federal Law titled Standards for Privacy of Individually Identifiable Health Information 45 CFR, Parts 160 & 164 and by Wisconsin Statute 146.82 Confidentiality of Patient Health Care Records, 51.30 Mental Health Act and 146.83 Access to Patient Health Care Records. Federal regulations prohibit you from making any further disclosure of this information without specific authorization for the release of medical or other information is not sufficient for this purpose.

A photocopy or fax copy is as valid as the original.