



Prairie Vision Center
of Bondurant

Release of Healthcare Information/Records

Authorization for use or disclosure of protected health information:

(Required by the Health Insurance Portability and Accountability Act)

Patient: _____
First Name Middle Initial Last Name

Date of birth: _____
MM/DD/YYYY

Authorized releasing provider/clinic: _____

Authorized recipient: **Prairie Vision Center of Bondurant**
87 Paine St SE, Suite 3
Bondurant, IA 50035
Fax: 515-209-2500

This request and authorization applies to:

- All previous exam information.
- Most recent Exam
- Most recent Contact lens and/or glasses prescription:
 - o Including all brands and materials used in the latest order.
- Healthcare information relating to: treatment, condition, or dates of service specified below:

Right to Revoke: I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

Non-Conditioning: I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Re-disclosure: I understand that once my health information is disclosed, it may no longer be protected by federal privacy laws and could be re-disclosed by the recipient.

Expiration: This authorization will expire one year from the date of signature unless otherwise specified

here: _____
MM/DD/YYYY

X _____
Patient/Guardian Signature

Date: _____
MM/DD/YYYY