DOWNTOWN EYE CARE
BARBARA E EVANS, M.D.
400 Locust Street, Suite 230 **Phone: (515)281-0902**
Des Moines, IA 50309 **Fax: (515)281-0915**

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Birthdate: _____
Previous Name: (if applicable) _____
Address: _____
City: _____State: _____ Zip: _____
This will authorize:
Dr. Barbara E Evans, M.D.

To release the information listed below to
Doctor's Name and Facility: _____
Address: _____
City: _____State: _____ Zip: _____

___ Medical and Exam information
___ Glasses Prescription
___ Contact Lens Prescription

THIS WILL AUTHORIZE FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW. I SPECIFICALLY AUTHORIZE THE RELEASE OF DATA AND INFORMATION RELATING TO:

Circle One:

Yes	or	No	Substance abuse (alcohol/drug use)
Yes	or	No	Mental Health/Depression (includes psychological testing)
Yes	or	No	HIV related information/AIDS testing

This authorization will automatically expire one year from the date of signature or until _____. I understand that I may revoke this consent at any time by notifying the above named provider of information. Any release of information made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality.
RESTRICTIONS: This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Signature of Patient or legal guardian: _____Date_____
Relationship if not patient: _____

For office use only : Faxed to: _____ By: _____ Date: _____