Burlington Eye Care
Wade A. Horn, O.D./Michael D. Matthews, O.D.
3303 E. Memorial Dr.
Muncie, IN 47302
Phone (765)282-2020 Fax (765)284-1150

**Protected Health Information Release Form**
**(HIPAA Release Form)**

Name:_____ Date of Birth ____/____/____

Release of Information

[ ] I authorize the release of my medical/vision and protected health information from Burlington Eye Care; including all medical records, diagnoses, examination/test results, treatment, appointment times and information, claims information, and fees charged.

This information may be released to (please list names below):
[ ] Spouse_____
[ ] Children_____
[ ] Other_____
[ ] Information is not to be released to anyone.

**This Release of Information will remain in effect until terminated by me, in writing.**
Please call: [ ] my home [ ] my work [ ] my cell number_____

If unable to reach me:
[ ] You may leave a detailed message
[ ] Please leave a message asking me to return your call

Signed:_____Date:_____/_____/_____

HIPAA Reviewed _____ (Initial) Date: _____

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