AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

Patient Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

A. Person (s) or Organization(s) authorized to provide the information:
NAME: _____
ADDRESS: _____
PHONE: _____FAX: _____

B. Person(s) or Organization(s) to receive the information:
HEART OF AMERICA EYE CARE P.A.
8800 WEST 75 STREET, SUITE 140
SHAWNEE MISSION, KS 66204
PHONE: 913-362-3210 FAX: 913-362-0407

C. Specific description of the information that may be used or disclosed (including date[s])":

D. Specific description of how the information will be used:

1) I understand that this authorization will expire on: _____.
2) I understand that I may revoke this information (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the above indicated provider.
3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may inspect or copy any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

NOTE:
*You have the right to know specifically what information you are authorizing for release (e.g. "results of a lab test performed on 01/04/2003" or, if your entire medical record is included, "all health information.").
*You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g. the names of your health care provider[s]).
*You have the right to know who is going to use this information and what it is going to be used for (e.g. John Smith, PhD/Research).