



Heart of America

EYE CARE P.A.

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.
8901 WEST 74 STREET, SUITE 285
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).