Authorization Form

The EyeCare Center
124 N. Mill St. Beloit, KS 67420
128 W. Kansas Ave. Smith Center, KS 66967
(785) 738-3816 (785) 282-6086
Office contact person: Seth Golding

Authorization for Release of Identifying Health Information

Patient Name: _____

Patient Birthdate: _____ Patient Phone Number: _____

Patient Address: _____

The office of Drs. Thompson and Olson Optometrists is authorized to release health information identifying the above named patient under the following terms and conditions:

1. **Information to be released:** _____
2. **Name of entity to which PHI will be released:** _____
3. **Purpose of release:** _____
4. **Expiration date or event:** _____

It is completely your decision whether or not to sign this authorization form. Signing this form is voluntary. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have on file, before deciding whether to sign this authorization. Our *Notice of Privacy Practices* explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office contact person, listed above, to initiate the process.

If you sign this authorization, you can revoke it at any time, except regarding information we have already used in reliance upon the authorization. If you want to revoke your authorization, send us written notification telling us that your authorization is revoked. Send this note to the office contact person listed above. Unless otherwise revoked, this authorization will expire 365 days from the date entered below. Once disclosures have been made, the information may be subject to re-disclosure by any recipient and no longer protected by federal privacy law.

When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

We will not receive a direct, financial benefit from disclosing this health information about you.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.

_____ _____
Signature Patient/Legal Representative Date

If signing as a legal representative, describe the relationship to patient and source of authority.

_____ _____
Source of Authority/Relationship to Patient Print Name

Legal Representative Telephone & Address: _____