Michael J. Atteberry, OD
Whitney T. Coleman, OD

3201 Iowa St. **Lawrence, KS 66046**
785-841-2020 **Fax 785-841-0420**

Authorization for Use or Disclosure of Health Information

Patient Name: _____ **Date of Birth:**_____

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" under a federal health privacy law, as described below:

Specific Description of the Information to be Used or Disclosed including the Date of Service(s):

I Hereby Authorize:	To Disclose to:
_____	_____
_____	_____
_____	_____
_____	_____

The protected health information will be used and/or disclosed for the following purposes:

(x) At the request of the individual

( ) Other: _____

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying the office of Michael J. Atteberry, OD and Whitney T. Coleman, OD in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Michael J. Atteberry, OD or Whitney T. Coleman, OD before receiving my revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in health plan, or eligibility for benefits.

_____ _____

Signature of Patient Signature of Personal Representative

Date:_____