ATTEBERRY
EYE CENTERS

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:

( ) 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 Atteberry Eye Centers in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Atteberry Eye Centers 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: ____________________________

atteberryeyecenters@gmail.com
2144 SW 36TH Street Topeka, KS 66611 | P: 785.266.1010 | F: 785.266.5312
5100 Bob Billings Parkway #100 Lawrence, KS 66049 | P: 785.841.2020 | F: 785.841.0420