PATIENT AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORATION

2720 E. 21st Street
Wichita, KS 67214
316-686-7212
Fax (316) 686-0338

2251 N. Woodlawn
Wichita, KS 67220
316-686-6063
Fax: (316) 686-4214

2508 Edgemont Drive
Arkansas City, KS 67005
620-442-2577
Fax: (620) 442-2578

2312 West Pawnee
Wichita, KS 67213
(316) 337-5483
Fax: (316) 558-3181

Name of Patient (Please Print)____DOB____________

Address ____Apt # ____________

City/State/Zip ____

Maiden name or the name used for records ____

I herby authorize: (please print) To release to: (please print)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

The following information from my records:

___Last Exam; including any testing

___Records from time period ________________to______________

___Complete Medical History

The information is disclosed for the purpose (s) of ____________________________________

Specify the date, extent or condition upon which this authorization expires___________________

I understand that I have the right to revoke this authorization at any time by contacting in writhing, FAX or email the Privacy Official noted in the Notice of Privacy Practices.

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

I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies up to $15.00 plus a copying charge of $0.20 per page.

I HAVE READ AND UNDERSTAND THIS FORM AND AM SIGNING IT VOLUNTARILY"

TMS Eyecare is not responsible for completeness, legibility, or omittance caused by the copying of any medical records from another institution.

Signature of Patient or Pateint's Representative ________________________________Date____________

Signature of Witness ____Date____________