Wichita Optometry, P.A.

2635 W Douglas | Wichita, KS 67213 | Ph: (316) 942-7496 | Fax: (316) 239-2557

PATIENT AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

* Please complete all items. An incomplete request may result in delay of release of records. Please print. *

Name of Patient Date of Birth

Street Address City State Zip Phone

Maiden Name or other name used for records

I hereby authorize:

______________________________ Phone #______________

Name of person or place records are requested from

______________________________ Fax #______________

Address of person or place records are requested from

To release to:

______________________________ Phone #______________

Name of person or place records are to be sent to

______________________________ Fax #______________

Address of person or place records are to be sent to

The following information from my records:

- o Last Exam; Including most recent tests (VF, OCT, PACH, ETC…)
- o Records from time period ______________________ to ______________
- o Complete Medical History

What is the purpose of the use/disclosure: o Changing providers-**permanent transfer of care** o **yes** o **no**
o Patient personal use o Other ______________________

This authorization will expire one year from the date listed below or on ___/___/_____ or occurrence of specified event at which time this authorization to use or disclose the identified health information expires, but no later than **one year** from the date listed below.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization.
I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
I understand that Wichita Optometry, P.A. may charge a fee for the costs of copying, mailing, or other supplies and services associated with this request. I understand Wichita Optometry, P.A. may use a business associate for copying requested medical records as described in the Notice of Privacy Practices.
I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in Wichita Optometry, P.A.'s Notice of Privacy Practices by mailing or hand-delivering written notification to the following person:
Attn: Privacy Officer, 2635 W. Douglas, Wichita, KS 67213.

Wichita Optometry, P.A. is not responsible for completeness, legibility, or omittance caused by the copying of any medical records from another institution.

Signature of Patient or Patient Representative **Date**

Printed Name of Patient Representative and Relationship Patient Representative address and phone number