STILES
EYECARE
EXCELLENCE
CATARACTS AND GLAUCOMA

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____Date of Birth:_____
Street Address:_____Telephone:_____
City:_____State:_____Zip Code:_____

I hereby authorize the use of the Protected Health Information described below to be provided to or obtained by the following:

Name of person(s)/organization to **Disclose** PHI
_____
_____
_____

Name of person(s)/organization to **Receive** PHI
Stiles Eyecare Excellence
7200 W 129th St. Overland Park, KS 66213
P: 913-897-9299 F: 913-897-3031

Information authorized for use or disclosure:

___ Complete health record **___ Visual fields/photos**
___ Other_____

Covering the periods of Health Care: From _____ to_____

The information will be used/disclosed for the following purposes:

___ Continued Treatment **___ Insurance** **___ Legal**
___ Other_____

I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and substance abuse.

I understand:

- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I may refuse to sign this authorization and that my refusal to sign will not affect may ability to obtain treatment. I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization.
- The entity authorized to disclose the health information will not be compensated by the recipient for the disclosure except for the cost of copying and mailing as authorized by law.
- I have a right to revoke this authorization in writing any time by submitting my revocation to the health information management department except to the extent that action has already been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 180 days from the date signed.

Signature_____Date:_____

Description of authorized representative's authority_____