LAWRENCE EYE CARE ASSOCIATES, P.A.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Lawrence Eye Care Associates, P.A. is required to obtain your authorization for any use or disclosure of your protected health care information (PHI) for purposes other than treatment, payment or health care operations. You have a right to review our Notice of Privacy Practices before signing this authorization.

PATIENT NAME _____ DOB____/____/____ SSN_____-_____-_____

PHI – RELEASE FROM:	**PHI - RELEASE TO:**
Lawrence Eye Care Associates, P.A. **1112 W 6th St, Suite 214** **Lawrence, KS 66044** **785-841-2280**	_____ **Name** _____ **Address** _____ _____ _____ **City** **State** **Zip** _(____)_____ _(____)_____ **Phone** **Fax**
PURPOSE OF DISCLOSURE: ☐ CONTINUITY OF CARE ☐ SELF ☐ OTHER (LIST BELOW) _____	**EXPIRATION DATE OF AUTHORIZATION:** ____/____/____ **If not noted – this authorization will expire 90 days from the date it was signed.**

REPORT	**VISIT DATE(S)**
☐ Physician Notes / H&P	_____
☐ Operation/Procedure	_____
☐ Special Testing	_____
☐ Radiology	_____
☐ Lab/Pathology	_____
☐ Other_____	
☐ Other_____	

☐ **I authorize the release of my complete health record (including records relating to mental healthcare, HIV or AIDS, and the treatment of drug or alcohol abuse).**

OR

☐ **I authorize the release of my complete health record with the exception of the following records (PLEASE CHECK BELOW):**
☐ HIV/AIDS ☐ DRUG/ALCOHOL ☐ OTHER_____

You may:

- **Request to inspect or copy the information that LECA intends to disclose.**
- **Revoke this Authorization in writing at any time, by delivering a written revocation to Administration, Lawrence Eye Care Associates, P.A., except to the extent that LECA has already released information in reliance on this Authorization.**

LECA may:

- **NOT require that you sign this Authorization to receive treatment.**
- **Assess appropriate and reasonable fees for the copying of information. Such fees will comply with federal and state laws.**

I have read the above information and authorize Lawrence Eye Care Associates, P.A. to disclose the identified information to the person(s) and for purpose described herein. I understand that, by signing this document, I release and discharge Lawrence Eye Care Associates, P.A. from any and all liability and will hold Lawrence Eye Care Associates, P.A. harmless for any release made pursuant to this Authorization. I understand that if the person or entity that receives the described information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by those regulations.

_____ ____/____/____ _____
Signature of Patient, Guardian or Authorized Rep Date Relationship

_____ ____/____/____
Witness Date