PERMISSION TO RELEASE INFORMATION FORM

THIS NOTICE DESCRIBES HOW MEDICAL/BILLING INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY. CHANGES/UPDATES ON THIS FORM WILL BE INITIATED BY THE PATIENT.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits whom we can discuss your health/billing information with. If there is a person or persons with whom you would like us to be able to discuss you or your dependent's health/billing information, you must designate them below.

This form must be signed and dated in order for Wichita Optometry P.A. to disclose or discuss any medical/billing information on behalf of the patient.

Patient Name:	**Date of Birth:**

Patient Address:

I authorize Wichita Optometry P.A. to discuss or release medical/billing information to the following individuals: Do not put your doctors on this form.

Name(s) of Authorized Person(s)	**Relationship to Patient**	**Information to be Disclosed**

In signing this authorization, I understand and acknowledge the following (please initial by statement):

_____To the individual(s) listed above, Wichita Optometry P.A. is able to discuss or release information necessary for the purpose of treatment, coverage/benefit inquiries, claim/billing inquiries, appeals, health care operations and/or questions about my health care and I acknowledge that the information released may include individually identifiable health information for me.

_____This information is being made at my request.

_____I understand that this authorization is voluntary and that I may refuse to sign it.

_____I understand that my refusal to sign this authorization will not affect my ability to obtain treatment/care.

_____I understand that I may revoke this authorization at any time by notifying Wichita Optometry P.A. in writing and all future disclosures will then cease. However, such revocation will not affect any disclosures we have already made based on your prior consent.

_____I understand that once the disclosures authorized herein have been made the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

_____I understand that unless otherwise revoked in writing, this authorization will remain as part of my medical record.

_____I understand that as a patient I have the right to restrict the uses of the information but Wichita Optometry P.A. does not have to agree to those restrictions.

_____I acknowledge that Wichita Optometry P.A. provided me with a Notice of Privacy Practices.

____ ____

Date Signature of Patient/Legal Representative Relationship to Patient

____ ___________

Address of Legal Representative Telephone #