AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION TO HEART OF AMERICA EYE CARE

Patient:_____ Date of Birth: _____/_____/_____

Address:_____ Phone:_____

I hereby authorize:

Discover Vision Centers (records previously at KC Eye Specialists)
11500 Granada
Leawood KS 66211
Phone: 816-478-1230 **Fax: 816-350-6980**

to release the information detailed below to:

Dr. Caroline Chang
Heart of America Eye Care P.A.
8901 West 74th Street, Suite 285
Shawnee Mission, KS 66204
Phone: 913-362-3210 **Fax: 913-362-0407**

Description of health information that may be used or disclosed: **ALL HEALTH INFORMATION**, or other, *please specify*:

The information will be used or disclosed for: **CONTINUATION OF CARE**, or other, *please specify*:

I understand that I may revoke this authorization in writing at any time by sending a written request to the practice at the above address, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that information disclosed pursuant to this authorization potentially could be subject to re-disclosure by the recipient, and if re-disclosed, the information would no longer be protected by the federal privacy rule.

This authorization shall expire on _____ (or 90 days from date signed if left blank).

By signing below, I acknowledge that I have read and I understand this authorization form.

_____ _____
Signature of Patient or Patient's Legally Authorized Representative Date of Signature

If signed by patient representative, describe authority to act for patient:

_____

_____
Printed Name of Patient's Representative