SOMERS EYE CENTER

HIPPA COMPLIANCE AUTHORIZATION

FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

NAME _____ DOB _____ By signing this form I authorize the use and discloser of my health information as described in the Notices of Privacy Practices. I have been given a copy of the Notice of Privacy Practices to read and keep if I desire.

To revoke this authorization, I must do so in writing and send to Somers Eye Center, Attention: HIPPA Compliance Officer, 2790 Clay Edwards Dr. Ste 1240, North Kansas City, Mo. 64116. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the federal Privacy Standards.

I authorize Somers Eye Center:

_____ Speak directly to me and may not give information to anyone else.

_____ May leave a message on my phone #_____

_____ May disclose information to the following person or persons;

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

GUARDIAN OR PERSONAL REPRESENTATIVE: _____