# CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient: ______________________ Date of Birth ______________

AUTHORIZE & REQUEST:

**DOCTOR OR HOSPITAL: ____________________________________________________________**

**ADDRESS: ____________________________________ (P): __________________ (F): _________________**

RELEASE TO:

**SOMERS EYE CENTER 2790 CLAY EDWARS DR STE 1240 NORTH KANSAS CITY MO 64116**

**PHONE: 816.842.2015 FAX: 816.221.3713**

THE FOLLOWING RECORDS: _____________________________ (SPECIFY ALL OR WHAT PORTION OF RECORDS)

PURPOSE OF REQUESTING RECORDS: ________________________________________________

I UNDERSTAND THAT IF IN MY MEDICAL RECORD IT CONTAINS INFORMATION CONCERNING HIV (AIDS) OR DRUG OR ALCOHOL ABUSE, THOSE PORTION OF MY MEDICAL RECORD ARE PROTECTED BY STATE AND FEDERAL LAW. I HEREBY RELEASE AND FOREVER DISCHARGE SOMERS EYE CENTER, ITS PHYSICIANS AND EMPLOYEES OR AGENTS FROM ANY LIABILITY ARISING OUT OF THE RELEASE OF MY MEDICAL RECORD AS SPECIFIED ABOVE AND PURSUANT TO THIS SIGNED AUTHORIZATION.

THIS CONSENT IS SUBJECT TO WRITTEN REVOCATION AT ANY TIME, EXCEPT TO THE EXTENT THAT THE DISCLOSURE HAS ALREADY TAKEN PLACE IN RELIANCE ON IT. IF NOT PREVOUSLY REVOKED, THIS CONSENT WILL TERMINATE ON ______ IF LEFT BLANK THIS EXPIRES ONE YEAR FROM THE DATE SIGNED.

PRINT PATIENT NAME: _________________________________________________________________

PATIENT SIGNATURE: __________________________________________________________________

SIGNATURE OF PARENT OR GUARDIAN: ______________________________________________________

RELATIONSHIP IF NOT THE PATIENT: _______________________________________________________

MONTH DAY AND YEAR: __________________________________________

INFORMATION DISCLOSED AS REQUESTED IN THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY THE FEDERAL HIPAA RULE.

TREATMENT MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORZATION UNLESS TREATMENT IS RESEARCH RELATED AND THE AUTHORIZATION OR FOR USE OR DISCLOSURE FOR SUCH RESEARCH.

WRITTEN REVOCATION MUST BE SUBMITTED TO: PRIVACY OFFICIER, SOMERS EYE CENTER, 2790 CLAY EDWARDS DR. STE 1240, NORTH KANSAS CITY, MO. 64116