

**K.C. EYE SPECIALIST MDs PC**

**CONSENT FOR RELEASE OF MEDICAL HEALTH INFORMATION  
TO K.C. EYE SPECIALISTS MDs PC**

Name of Patient/Individual: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

I authorize \_\_\_\_\_ located at

\_\_\_\_\_

to use or disclosure my health information, as described below.

1. Description of health information that may be used and/or disclosed:

\_\_\_\_\_

2. Name(s) of organization(s), person(s) or class of persons who may receive and use the information:

K.C. Eye Specialists M.D.s P.C.  
9009 Roe Avenue  
Prairie Village, KS 66207  
Tel. (913) 385-9009  
Fax (913) 385-3005

3. The purpose(s) for which the information will be used or disclosed:

\_\_\_\_\_

4. 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 redisclosure by the recipient, and if redisclosed the information would no longer be protected by the federal privacy rule.

5. This authorization shall expire \_\_\_\_\_ (or 90 days of 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 Authorized Representative      Date

If signed by Patient's Representative, please print name and describe the representative's authority to act for the patient:

Representative's Name: \_\_\_\_\_

Representative's Authority: \_\_\_\_\_

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN  
TO THE PATIENT OR PATIENT'S REPRESENTATIVE