SOMERS EYE CENTER
HIPAA COMPLIANCE AUTHORIZATION
FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

2790 CLAY EDWARDS DRIVE
SUITE 1240
NORTH KANSAS CITY, MO 64116
816-842-2015

By signing this form I authorize the use and disclosure 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 Drive, Suite 1240, North Kansas City, Mo 64116. I understand that it is possible that information used or disclosed with my permission may be re-disclosed 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 disclose information to the following persons;

Name__________________________________Phone____________________

Name__________________________________Phone_____________________

____ May leave messages on my phone.

I understand that Somers Eye Center may not condition treatment on my signing this authorization and that I may have the right to refuse to refuse to sign authorization.

Signature______________________________Date____________________________
Print Name____________________________

Guardian or personal representative_______________________________________

**** If an authorization is signed by an individual's personal representative, the representative's authority is based on__________________________(law, court order, etc.)**