Midwest Eye Care, P.C.
Since 1951, Focused on you

Main Office:
4353 Dodge Street
Omaha, NE, 68131
(402) 552-2020
Fax: (402) 552-2367

For Office Use Only

Patient #: Received:
Date Sent: Initials:

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

____
(Patient name) (Birth date) (Social Security Number)

____
(Street address) (City) (State) (Zip) (Telephone)

This information is to be used for (please specify reason for release of information, e.g., continuing medical care, 2nd opinion, moving to new area, etc.) ____

Please indicate specific medical information needed and for what time period:__________________
____

The undersigned hereby authorizes the third party listed below to use and/or disclose to Midwest Eye Care the information described above including, if applicable, the following health information related to testing, diagnosis, and/or treatment for (please initial applicable lines): ______ HIV (AIDS virus), ______ sexually transmitted disease, ______ mental health, or ______ drug and/or alcohol abuse.

____
(Name of institution and preferably the name of an individual to whom to direct this request)

____
(Street address) (City) (State) (Zip) (Phone)/(Fax)

Important Privacy Information – Please Read before Signing this Authorization

Conditions: A health care provider may not condition your right to receive health care services upon your signing this authorization. However, if treatment to be provided is for research purposes, your failure to sign this authorization may prevent a provider from providing such treatment.

Further uses and disclosures: When a health care provider uses or discloses your health information as you have instructed in this authorization, they do not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws.

Expiration: This authorization shall expire upon the earlier of __________________ or one year from the date of this authorization. After the expiration date, the health care provider will need to obtain a new authorization from you if required by law.

Revocation: You have the right to revoke this authorization at any time by providing the health care provider listed above with written notice by certified mail, fax or hand delivery. When they receive your revocation, they are obligated to stop using or disclosing the health information you authorized them to use or disclose in this authorization form. Your revocation shall not apply to those uses and disclosures they made on your behalf pursuant to this authorization prior to the time they received your written revocation.

Acknowledgement: By signing above, you acknowledge receipt of a signed copy of this authorization.

____________________________________ ______________________________
(Signature of patient, guardian or authorized representative; if other than the patient, we need written proof of your authority) (Witness)

____________________________________ ______________________________
(Date) (Relationship of above person to patient)

This form is used when a third party is to disclose health information to Midwest Eye Care.