**Authorization for Records Release - Midwest Family Eyecare**

**I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Person (s) or Organization(s) authorized to provide the information:**

Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Person(s) or Organization(s) to receive the information:**

Drs. Laura Brammer, OD and Stephanie Erker, OD

13600 Washington Street

Kansas City, Missouri 64145

PHONE: 816-888-5400 FAX: 816-888-5401

1. **Specific description of the information that may be used or disclosed**

Patient Demographic and Insurance Form

All Examinations

Any additional testing: OCTs, Visual Fields and Photos

1. **Specific description of how the information will be used:**

Transfer of Care

1. **Expiration of Release:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient or Parent Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient Representative Relationship to Patient

**Patient Rights Notification**

You have the right to know what information you are authorizing for release, to whom and from whom it is being released and how it will be used.

You have the right to refuse to sign this authorization.

Please request a copy of this authorization for your records if desired. You may inspect or copy any information being provided.

You have the right to revoke this information at any time by notifying the provider listed above.