RELEASE OF PROTECTED HEALTH INFORMATION FORM

Authorization to release protected health information from:			
Name(s)	**ADDRESS**		
CITY, STATE	**ZIP**	**PHONE**	**FAX**
Please release the following information: *LAST EYE EXAM AND ALL EYE TESTING*	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ❑ **NEVER DATE:**		

Authorization to release protected health information to:			
Name(s) **ICT EYE, LLC**	**ADDRESS** **9050 E. 29th Street North Ste 40**		
CITY, STATE **Wichita, Kansas**	**ZIP** **67226**	**PHONE** **(316) 425-0445**	**FAX** **(316) 425-0460**
AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ **NEVER DATE:**			

RELEASE OF INFORMATION

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission
- This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.
- I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

PRINT PATIENT NAME **DOB**	**DATE**	**PHONE NUMBER**
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE**	