SHARPER VISION
913.787.6724
www.sharpervisionks.com

Consent for Release of Confidential Medical Information

I, _____, BORN _____
patient name — date of birth

AUTHORIZE & REQUEST:

_____
specify practice/facility or physician name

_____
address of practice or physician

_____

TO FURNISH TO:

_____
specify recipient of patient records

_____
address of practice or physician

_____

THE FOLLOWING INFORMATION: _____
specify all or what portions of records

_____

PURPOSE OF DISCLOSURE: _____
this information is released for this purpose and this purpose only

_____

I understand that if my medical record contains information concerning HIV (AIDS) or drug or alcohol abuse, those portions of my medical record are protected by state or federal law. I hereby release and forever discharge Sharper Vision, PA, it's physicians and employees, or agents from any liability arising out of the release of my medical records as specified above and pursuant to this signed authorization.

This consent is subject to written revocation at any time*, except to the extent that the disclosure has already taken place in reliance on it. If not previously revoked, this consent will terminate on: _____ . If left blank this consent expires in one year.
date of termination of consent

_____ _____
signature of patient — month day year

_____ _____
signature of parent, guardian, or authorized representative — nature of relationship

_____
witness

Information disclosed as requested in this authorization may be subject to redisclosure by the Recipient and may no longer be protected by the federal HIPAA rule.

Treatment may not be conditioned on signing this authorization unless treatment is research related and the authorization is for use or disclosure for such research.

* Writen revocation must be submitted to: Sharper Vision, PA, at 23351 Prairie Star Parkway, A-275, Lenexa KS 66227.