

PATIENT AUTHORIZATION FORM

KIRBY EYE CENTER
204 GATEWAY NORTH #A
MARBLE FALLS, TX 78654
OFFICE: 830-693-5868
FAX: 830-798-8017

Date Requested: _____

I, _____, hereby authorize you to use or disclose the medical records, including any visual fields to Kirby Eye Center. This information is being requested to aid in my diagnosis.

I understand that:

I may inspect or copy the protected health information to be used or disclosed.

I may revoke this authorization in writing by contacting your office at the address listed, attention Privacy Officer.

Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.

I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment)

If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Signature _____ D.O.B. _____

Relationship to Patient: _____

Requesting information from:

Name: _____

Address: _____

Phone: () _____ Fax () _____

**PLEASE RETURN *COMPLETED* FORM
AS SOON AS POSSIBLE
to Kirby Eye Center**