Keil Lasik Vision Center

www.keillasik.com

Authorization for Release of Medical Information

I, _________________________________ (Print Name of Patient), hereby authorize

____
Doctor/Facility

____
Address

____
City, State and Zip Code

To release my individual medical information as described below:

___Complete Treatment Record without limitation
___Treatment Record of the following date(s)______________________
___Billing and payment records
___Other (describe):____

I authorize the following person(s) or organization to receive the information:

Keil Lasik Vision Center
2500 East Beltline Ave. SE Suite C
Grand Rapids, MI 49546

I authorize the release of any information contained in my treatment records that might include information concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological condition and/or psychiatric/mental health treatment and/or HIV related conditions.
_____ (Patient Initial)

The reason for the request for my information:
____

Re-disclosure: I understand that my treatment information released under this consent may be re-disclosed by the recipient of the information and may no longer be protected by Federal Law. If the information released under this consent includes alcohol or drug treatment records, the person(s) receiving this information are hereby notified that this information is from records protected by Federal confidentiality rules. The Federal rules prohibits such person(s) from making any further disclosure of this information without specific written consent of the person authorizing this release or as otherwise permitted by 42 CFR Part 2.

Expiration: This authorization will expire in ninety (90) days after the date below, or sooner by choice, in which case this authorization will expire on _________________ (insert date), except to the extent action has already been taken in reliance upon this authorization. You may not indicate there is "no expiration," "does not expire," or "none."

Revocation: I understand that I may revoke this authorization at any time by notifying Keil Lasik Vision Center, in writing. I further understand that the revocation will not apply to information that has already been released in response to this authorization.

Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law.

If I have questions about disclosure of my health information, I can contact Keil Lasik Vision Center.

______________________________________	________________________
Signature of Patient/Legal Representative	Date

____
If signed by Legal Representative,
Relationship to Patient

*Patient's Date of Birth:___________________________

**The above information is required in order to verify the identity of the patient and to locate the patient's medical information.*

Failure to fully and legibly complete this authorization for release of medical information may result in the inability of this authorization to be honored.

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