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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

There is a processing fee of $17.05 plus $0.40 per page. There will be a $2.00 fee if Notary services are required and additional charges for packaging and postage if requesting a CD.
Please allow 7-10 business days for processing.

Select one: ☐ CD ☐Fax (___)_____-_____ or ☐ Secure e-mail _____@_____

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Person(s)/Organization to **Disclose** PHI:
Murphy, Watson, Burr Eye Center
5202 Faraon Street
St Joseph, MO 64506
Medical Records Dept:
Phone: 816-649-6068
Fax: 816-632-2342

Person(s)/Organization to **Receive** PHI:
_____
_____
_____
_____
_____

Information authorized for use or disclosure:
☐ Complete Health Record ☐ Progress Notes ☐ Tests/Labs ☐ Other: _____

Covering the period of Health Care from _____ to_____

For the purpose of ☐ Continued treatment ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and substance abuse.

I understand:

- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization.
- The entity authorized to disclose the health information will not be compensated by the recipient for disclosure, except for the cost of copying and mailing as authorized by law.
- I have the right to revoke this authorization in writing at any time by submitting my revocation to the health information management department except to the extent that action has already been taken in reliance on this authorization. **Unless otherwise revoked, this authorization will expire on _____ or within one (1) year from the date signed if I have not provided an expiration date.**

_____ _____
Signature of patient or authorized representative Date

_____ _____
Witness signature Date