# *Kendall L. Krug, OD, PA*

*2203 Canterbury Dr.*
*Hays, KS 67601*

*785-625-3937 (P)*
*785-625-7490 (F)*

## Authorization for Release of Protected Health Information

Patient Name: _____ Date Of Birth: _____

Address: _____ Phone Number: _____

I hereby authorize (name of provider **releasing** information) to disclose the above-named individuals health information:

| | | |
|---|---|---|
| | | |
| Name (**FORMER Eye Doctor/Facility**) | Phone # | Fax # |

Information to be released:

☐ Records/Progress Notes ☐ Spectacle Rx (if applicable) ☐ Contact Lens Rx (if applicable)

This information may be disclosed to and used by the following individual/organization:

| | | |
|---|---|---|
| Kendall L. Krug, OD | 785-625-3937 | 785-625-7490 |
| Name (Eye Doctor/Facility) | Phone # | Fax # |

Purpose of the use and/or disclosure:

☐ Continuing Care ☐ Personal Use ☐ Emergency/acute care

I understand that the authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy regulations. The office of Dr. Kendall L. Krug, OD PA, may charge a fee for this service. The authorization will expire by law 180 days from the date of this authorization unless I otherwise specify.

I further understand that I may revoke this authorization at any time by notifying the HIPPA Privacy Officer at Dr. Kendall L. Krug, OD PA. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Patient/Representative Date

_____ _____

Printed Name of Patient/Representative Relationship to Patient

*Office Staff Witness Initials:* _____