KIRK EYE CENTER

PERMISSION TO TREAT

I, the undersigned, ___ parent___ legal guardian, do hereby give Kirk Eye Center physicians permission to treat_____, my____ child ____ ward, for any vision or other problems related to his/her eyes using whatever ophthalmic treatments that Kirk Eye Center provider deems medically necessary. This may include tests that are needed for the diagnosis of the condition for which the patient is being seen. This permission is valid for one year from this date, or until _____, _____, which date is less than one year from the date below.

I also authorize the following individuals to access my ___child's ____ward's medical records.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I further authorize the release of my ____child's ____ ward's medical record information for purposes of obtaining payment or any further treatment necessary.

Financial Responsibility

_____ shall be financially responsible for any charges related to this visit, and any subsequent visits, until the expiration date specified above. This will be accomplished by billing the insurance plan or individual as specified above.

Signature of Parent or Guardian_____

KIRK EYE CENTER
HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

_____ _____
Patient Name Guardian or Authorized Party Name (if applicable)

_____ _____
Social Security Number Date of Birth

I authorize the use and disclosure of my health information on as described below:

Information Requested:

_____ Records relating to treatment dates from: _____ to: _____

_____ Records for all care at this facility or by this doctor.

_____ Other (Please Specify) _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire in 90 days from today's date.
I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Information to be released [ ] from [ ] to _____

_____

_____

[ ] from [ ] to **KIRK EYE CENTER**
3650 E. 15TH STREET
LOVELAND, CO 80538
PHONE (970) 669-1107
FAX (970) 669-8849

_____ **(Initials of patient or guardian)** I understand that KIRK EYE CENTER, PC, may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

_____ _____
Signature of Patient or Guardian ** Date
A fax copy or photocopy of this consent shall be as valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions, I DO_____ DO NOT_____ authorize the release of this information.

** If this authorization is signed by an individual's personal representative, the representative's authority is based on:
_____ (e.g., state law, court order, etc.)

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee is $15.00 for the first ten pages and $.30 for each additional page. No fee shall be charged for reproducing and forwarding records directly to other physicians.

For office use only:
Physician Authorization _____ Date sent: _____ By:_____