Kennedy Eye Associates and Roseville Opticians
1790 Lexington Ave N, Roseville, MN 55113
Tel: 651 488 6771 Fax: 651 488 5576
Ede Henry, Privacy Officer

Patient Authorization to Release Identifying Health Information

Today's date	Chart #

Patient name	Patient date of birth
Patient address	Patient home phone #
Patient city, state, Zip	Patient cellular phone #
Name of legal guardian	Guardian home phone #
Relationship to patient	Guardian office phone #
Source of authority	Guardian cellular phone #

Please note that we will provide eyecare services regardless of whether or not we are authorized to release the patient's identifying health information. Such authorization is completely the decision of the patient and his or her legal guardian or agent. This authorization may be revoked at any time by sending a written or electronic notice of revocation to the office contact person listed at the top of this form. The only exception to this right to revoke is if we have already acted in reliance upon this authorization prior to our receipt of a revocation.
When patient health information is disclosed as provided in this authorization, the recipient might not have any legal duty to protect its confidentiality and might subsequently disclose the patient's information to other individuals or entities. Federal and state laws regulate the disclosure of confidential healthcare information.
Representatives of the office listed at the top of this form may release the patient's name and identifying health information to other healthcare and medical insurance providers and prescription dispensaries, with the following exceptions and limitations:

1. Specific identifying health information that may not be released to anyone:

2. Names of individuals and entities to whom patient's identifying health information may not be released:

3. Expiration date or event which terminates this authorization:

I have read and understand this authorization form and I hereby authorize the disclosure of identifying health information relating to the patient named above and as explained in this form.

Authorizing Signature	Date of signature
Printed name of signature	