



Visual, Medical and Surgical Eye Care

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Medical Eye Care

Eye Disease
Eye Injuries / Infections
Glaucoma
Cataracts
Retinal Examinations
24-Hour Emergency Care

Eye Examinations

Adult, Pediatric & Infant

Surgical Eye Care

Laser Vision Correction
LASIK / PRK / CK
Eyelid Surgery
Cataract Surgery
Glaucoma Surgery

Contact Lens Care

General & Specialized

Optical Services

Certified Opticians
On-Site Laboratory
Glasses
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**FRONT RANGE EYE
HEALTH CENTER, P.C.**

Summit View
Professional Park
1220 Summit View Drive
Louisville, CO 80027

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Fax (303) 673-9578

www.FrontRangeEye.com

AUTHORIZATION FOR REQUEST OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ D.O.B: ____ / ____ / ____

Patient Address: _____ Phone: (____) _____

I authorize the professional office of my doctor, name circled to the left, to request health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

- Detailed description of the information to be released:
 All (no restriction)
 Describe Information: _____
- From whom is the information being requested [name(s) or class(es) of recipients]:
 Name: _____
 Address: _____
 Phone: (____) _____ Fax: (____) _____
- The purpose(s) for the request (it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
 At the request of the patient
 Other (describe): _____
- Expiration date or event relating to the individual or purpose for the request: _____

It is completely your decision whether or not to sign this authorization form. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed, as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes state or federal law changes this possibility.

If you are authorizing us to use your health information for marketing activities, please be advised that we may receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.
I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION
AS DESCRIBED IN THIS FORM.

Patient signature _____ Date _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____

CINDY J. BEEKS O.D., HIPAA COMPLIANCE OFFICER