

# Authorization for Use and Disclosure of Protected Health Information

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## **KORRECT OPTICAL** **Spencer Maudlin, O.D.** **Seth Summers, O.D.**

As required by the Health Insurance Portability and Accountability Act of 1996 Korrect Optical and Spencer Maudlin, O.D. and Seth Summers, O.D. may not use or disclose your health information except as provided in our notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosure described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

### AUTHORIZATION SECTION

I, \_\_\_\_\_ (print name) hereby authorize the use and disclosure of the following health information that pertains to me.

For the following purpose<s>:

I authorize the following persons to make these disclosures of my health information:

I authorize the following persons to receive these disclosure of my health information:

I understand that the information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire one year from the last date of service seen by this practice.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment and my eligibility for benefits will not depend in any way on whether I sign this authorization or not.

I understand that i have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

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Signature

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Date