CONSENT AND AUTHORIZATION FOR

RELEASE OF MEDICAL RECORDS

(Protected Health Information)

I, _____ (Patient Name) consent to the release and transfer of my entire optometric medical record, including all of my treatment records and protected health information and diagnosis and progress notes regarding general optometric services, contact lenses, eye testing results, laboratory results, cataract and refractive surgery co-managed records, surgery records, low vision services, dry eye treatment and therapy, and all other information and records regarding the treatment of my eyes:

To: Dr. Bruce Boyle 2757 S. Seneca St Wichita KS 67217

Ph. (316) 260-6280 Fax: (316) 665-6806

From:_____

_____

_____

_____

For the purpose of: continuing and/or transferring my care and treatment with/to Dr. Bruce Boyle. This consent and authorization is effective until the entire medical record, as described above is transferred.

I understand that I may withdraw this consent and authorization at any time, except to the extent that the medical records with protected health information have been released and transferred in reliance upon this consent and authorization, by mailing or hand delivering written notification to Dr. Bruce Boyle, 2757 S. Seneca St Wichita KS 67217.

_____ _____

Date Signature of Patient or Patient Representative

_____

Print Name of Representative / Relationship