KENNEDY
VISION HEALTH CENTER

10600 OLD COUNTY ROAD 15
PLYMOUTH, MN 55441
(763) 545-8850

18157 CARSON CT NW SUITE C
ELK RIVER, MN 55330
(763) 441-0205

Patient's Name: _____ Date of Birth: _____

Consent and Authorization to Release or Discuss Protected Health Information

1. Release of Information: I consent to the release and use by Kennedy Vision Health Center (referred to as "KVHC") of medical and other information about me to the extent permitted by law to the following:

    - To a health care provider being advised or consulted in connection with my treatment or care;
    - To a health plan, insurer, third party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews; and
    - To a person or organization in connection with KVHC's health care operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.
    - To the following individuals (name spouse, family member, employer, or any other individual):

    1._____ Relationship: _____
    2._____ Relationship: _____
    3._____ Relationship: _____

    ☐ I do not want my information shared with another party or individual (INC. INSURANCE)

2. Revocation: I understand that this consent shall continue until I revoke it, which I may do at any time by giving written notice to KVHC.

3. Once my information is shared with the person/s named above, it may no longer be protected by privacy laws. Kennedy Vision Health Center cannot prevent these persons from sharing my information with a third party.

Signature of Patient (if applicable): _____ Date: _____

Signature of Legal Guardian (if applicable**):** _____ Date: _____