FIRST EYE ASSOCIATES

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

ACCOUNT	**PATIENT NAME**	**DOB**
PATIENT ADDRESS		
RELEASEE		
RELEASER		
PURPOSE AND DATE RANGE		

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to First Eye Associates' Chief Compliance Officer at 8111 Dodge St, Suite 143, Omaha, NE 68114. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest claim.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

SIGNATURE & DATE	
PRINTED NAME	
RELATION TO PATIENT	