

LINDA M. LAWRENCE, M.D.

— *Ophthalmology* —

Surgery and Diseases of the Eye

1410 E. Iron, Suite 6 · Salina, Kansas 67401

Phone: (785) 823-1600 · Fax: (785) 823-8953

AUTHORIZATION FOR THE RELEASE AND/OR DISCUSSION OF PROTECTED
HEALTH INFORMATION

Patient Name _____ Birth Date _____

I, _____ hereby authorize
(Patient or legal representative)

Name of person, organization or physician

_____ To release my complete health record (including records relating to mental
healthcare, communicable diseases HIV/AIDS, and treatment of alcohol or drug abuse).

- _____ With the exception of:
_____ Mental Health Records
_____ Communicable Diseases (including HIV/AIDS)
_____ Alcohol/drug abuse treatment
_____ Other (specify) _____

To: Linda Lawrence, M.D., 1410 E Iron, Ste 6, Salina, Ks 67401

This information may be used for medical treatment, consultation, or other purposes as I
may direct.

I have carefully read and understand the above information, and do herein consent to its
disclosure. I am aware that information regarding my medical condition will be released
to those persons or agencies named above. I understand that this consent is subject to
revocation, in writing, at any time, unless action based on it has already begun. This
authorization expires one year from today's date.

Signature _____ Date _____

Relationship to patient _____

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