FAMILY EYE CARE

Member of the Vision Source Network

Consent for Release of Information to Authorized Individuals

Patient Name: _____ Date of Birth: _____

Many of our patients would like their Personal Health Information (PHI) released to other individuals, such as family members. PHI includes any information about health status, medical records, or payment for care. Under the requirements of HIPPA, we are unable to release PHI without a patient's consent.

If you wish to have your PHI released to an authorized individual(s), please complete and sign this form.

I authorize Family Eye Care to release my PHI to the following individual(s):

*Authorized Individuals:

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient:_____
4. _____ Relation to Patient:_____

Patient Information

I understand I have the right to revoke this authorization, in writing, at any time. Additionally, I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the authorized individual.

Patient Signature: _____ Date: _____

Legal Guardian's Signature: _____ Date: _____

Name: _____ Relationship: _____