Authorization Form to Release Protected Health Information (PHI)

This authorization grants permission to the party named below to: make or confirm appointments; have access to exams or test findings; have access to telephone communication and answering machine messages, as well as other common means of communication; pick up supplies such as contact lenses, glasses, or prescriptions; be made aware of my diagnosis, prognosis, and treatment plans; and have access to my financial health information.

I hereby authorize Family Eye Health to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to the party named below, the released information may no longer be protected by federal privacy regulations.

Name of Person Releasing PHI: _____

Date of Birth: _____

Name of Person Receiving PHI: _____

Relationship to Patient: _____

Address of Person Receiving PHI: _____

Phone Number of Person Receiving PHI: _____

Patient's Signature/Person Releasing PHI: _____

Date: _____