

Authorization for Release of Personal Health Information (PHI)

Patient Name: _____ DOB: _____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must complete this form. Signing this form will only give information to family members indicated below.

I authorize Monocle Eye Care & Eyewear Gallery to release my medical and/or billing information to the following individual(s).

_____ Relationship to Patient: _____

_____ Relationship to Patient: _____

_____ Relationship to Patient: _____

Patient Information:

I understand I have the right to revoke this authorization at any time and that 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 above recipient.

I understand revocation must be in writing and is not retroactive.

Signature: _____ Date: _____