GULFCOAST EYE CARE

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No
If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____
Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize _____ to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions.
I authorized you to use and disclose my contact information to your internal staff for the purpose of marketing communications or promotions pertinent to me.
This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed _____ Notice of HIPAA Privacy Policy. **A copy of this policy will be provided to me upon request.**

Patient Signature: _____ Date: _____

WITNESSED BY: _____