HIPAA Acknowledgement & Confidential Communication Request

AUTHORIZATION

I, _____ , GIVE MY PERMISSION TO Family Eye Center and/or any staff member of Family Eye Center, to discuss my health care with the individuals noted below who may, from time-to-time, help me receive and pay for health care. This may included, but is not limited to, attending my appointments, helping me follow treatment recommendations, picking up medications and/or RX, helping me understand my test results, helping me understand and make payments for my health care.

Name_____ Relationship_____ Phone# _____

Name_____ Relationship_____ Phone# _____

Please note: This form does not replace the release of Information form that must be completed to release PHI to another entity (person/business).

RESTRICTIONS

The following people shall not be allowed access to my Personal Health information:

Name_____ Relationship _____

Name_____ Relationship _____

Signature of Patient/Guardian: _____
Date of Birth:_____ Date: _____

Parent/Guardian Name (Please print): _____

If not signed by patient, please complete section below:

Name_____ Relationship_____