AdvancedEyeCare
AND OPTICAL

PERMISSION TO COMMUNICATE WITH FAMILY MEMBERS AND/OR OTHERS

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health care providers are prohibited from releasing or discussing any health information to anyone without appropriate permission. Therefore, we need your written authorization if you would like us to communicate with anyone other than the patient or the child's legal guardian(s). Please let us know with whom we may communicate regarding any aspects of ophthalmic care.

I _____, hereby give permission to Dr. Powers office staff to notify me by telephone and/or electronically of the following (check all that apply):

Yes □ No □ Appointment reminder, and eye wear status either by personal message or recorded message.

Yes □ No □ A message to call the office for test results. (At no time will actual test results be left by message).

The individuals listed below are authorized to receive the above information on my behalf:

_____

_____

_____

I understand this form is intended to guard my privacy and is not a release of general medical information.

_____ _____

PATIENT SIGNATURE (RESPONSIBLE PARTY) DATE

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) DATE