Patient Consent for Release of Medical Information

Due to the HIPAA laws that are now in effect, we must have your written authorization to release your medical information to a person other than yourself. Understand that your information may need to be discussed with your current physician or referred to/from specialists in regards to scheduling of procedures, consultations, and health history that may impact your vision and eye health. Only the information needed to do this will be released, with the exception of the recipients listed on this form. This release will be valid for one year from the date of signing.

1. Who may we release your medical information to?

(e.g. spouse or other family member)

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

2. May we send appointment reminders through the mail and/or e-mail?

□Yes □No

3. May we leave a message on your voicemail or text you to confirm an appointment?

□Yes □No

Patient Name (please print)_____

Signature_____

Date_____