Account #:_____

The EyeClinic

Medical Information Release Form
(HIPAA Release Form)

Patient Name:_____ Date of Birth: ____/____/____

Release of Information

( ) I authorize the release of information/property which includes: Appointment Schedule, Billing/Claims Information, Materials Pickup and Printed Medical Records Pickup. This information/property may me released to:

Please list any person(s) other than yourself, and their relationship to you that we may discuss your medical information with:

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Minor by:

Name:_____ Relation:_____

Name:_____ Relation:_____

( ) Information is not to be released to anyone.

This ***Release of information*** will remain in effect until terminated by me in writing.

Messages

Please call □my home □my work □my cell Number_____

If you are unable to reach me:

( ) You may leave a detailed message ( ) Please leave a message asking me to return your call

Legal Documents:

( ) Power of Attorney ( ) Custody Restraining/Restriction Paperwork
( ) Legal Guardianship ( ) Other:_____

Signed: _____ Date: ____/____/____