AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE

At Advanced Eye Physicians we realize it may be necessary to have someone else contact us concerning your health information. This may be for the purpose of billing, change of an appointment, or even to have a better understanding of your prescribed treatment or medical condition.

To make this process more convenient for our patients we are providing you with this disclosure form.

I, ___________________________, authorize Advanced Eye Physicians and staff to disclose health information to the below named individual(s) on my behalf. I release Advanced Eye Physicians and staff from any claim of confidentiality in connection with this release of information. I acknowledge that I may revoke this release at any time in writing.

1) Name of Designated Person: ____

Relationship: ___________________________ Phone number: _______________

2) Name of Designated Person:

____

Relationship: ___________________________ Phone number: _______________

Patient's Name: ____

Patient's Signature: ____

Date: __________________________ Witness: _____________________________