AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____ **Date of Birth:** _____/_____/_____/

RELEASE OF INFORMATION

I authorize my physician and/or administrative and clinical staff of **Balouris Eye Center, PC** to disclose medical information and other protected healthcare information to the following persons and or entities listed below.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend).

Name of Person:	**Relationship:**
_____	_____
_____	_____
_____	_____

Other Entity: _____

I hereby authorize **Balouris Eye Center, PC** to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions.

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

PHONE MESSAGES

Please call:

Home: _____ Work: _____ Cell: _____

If unable to reach me: ☐ you may leave a detailed message

☐ please leave a message asking me to return your call

The best time to reach me is (day) _____ (time) _____

I have reviewed the above information and provide my consent regarding any and all the issues as stated above.

Patient Signature: _____ **Date:** _____/_____/_____/

Witness Signature: _____ **Date:** _____/_____/_____/