The Eye Care Group, P.C.

Restricted Use and Disclosure of Protected Health Information

The Eye Care Group, P.C. is dedicated to maintaining our Privacy Policy and your Protected Health Information (PHI). To that end, we will communicate the results of your evaluation, treatment and/or surgery to your Referring Physician, Primary Care Physician and any other Specialists **directly** involved in the care that we provide to you.

Patient Last Name: _____ Patient First Name: _____

Date of Birth: _____/_____/_____

At my request, I authorize The Eye Care Group, P.C. to send and/or disclose/discuss my protected health information with a relative, family friend or third party provider listed below (in addition to the provider(s) described above): (*enter name of person/entity who you want to receive your protected health information):*

☐ Relative and/or Family Friend (**you must state relationship**):

Name: _____ Phone: (_____)_____ Relationship:_____

Name: _____ Phone: (_____)_____ Relationship:_____

☐ Other healthcare provider (i.e. therapist, social worker, etc.):

Name: _____ Phone: (_____)_____

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I authorize The Eye Care Group, P.C. to leave appointment reminders and limited confidential communications regarding my protected healthcare information on my (**check only one**):

☐ Home answering machine ☐ Cell phone ☐ Text Message ☐ Work voicemail ☐ Alternate number _____

☐ Please send my mail, including my bills to an alternate address: _____

_____

I authorize The Eye Care Group, P.C. to include my email address for marketing communications (newsletters, announcements) and understand that neither my email address, nor my protected health information will be disclosed, or shared with any other entity.

☐ Email address: _____.

Right to Revoke: I understand that I may revoke this Authorization at any time upon written request. I also understand that my revocation will not be effective as to uses and/or disclosure of my health information that the (person(s) and or organization(s) listed above have already made in reliance on this Authorization.

Revocation Date: This Authorization is valid until _____. If a date is not provided, The Eye Care Group, P.C. will accept this Authorization form for five (5) years from the date of my signature. I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient and/or Legal Representative: _____Date: _____/_____/____

Relationship to patient: _____ Authority for status as representative: _____