# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS

_____ DOB: _____ SS#:_____
Name of Patient

I understand that Ophthalmology Consultants/ The Center for LASIK from time-to-time may be requested to disclose my protected health information (PHI) with members of my family or a close friend. Therefore, I authorize Ophthalmology Consultants/ The Center for LASIK to disclose my PHI for the following purposes:

- ☐ Make an appointment for me
- ☐ Cancel an appointment for me
- ☐ Obtain test or lab results on my behalf
- ☐ Discuss my current health condition or symptoms
- ☐ Pick-up written prescriptions or pharmaceutical samples on my behalf
- ☐ Other: _____

with the following individuals:

| **Person's Name** | **Contact Phone #** | **Relationship to Patient** |
|---|---|---|
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I understand that if information is requested via telephone, the caller will be asked to identify me by providing (a) my social security number and my date of birth as shown on Ophthalmology Consultants/ The Center for LASIK's records, and (b) the caller's full name shown above. If the request is made in person, the individual will be required to provide proper identification, including a picture ID.

I understand that in order to add or delete designated people from this list, I must notify Ophthalmology Consultants/ The Center for LASIK in writing. I also understand that I may revoke this authorization in its entirety by providing written notification to Ophthalmology Consultants/ The Center for LASIK.

_____ _____
Print Name of Patient / (Personal Representative) Signature of Patient / (Personal Representative)

_____ _____
Personal Representative Relation to Patient Date signed