SHORELINE EYE GROUP

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

It is the policy of Shoreline Eye Group to work closely with other medical professionals involved in providing medical care to the patient. A patient may grant permission to expand this disclosure to other persons.

In the case where the patient has a grantor, POA or COP, this information must be made known to Shoreline Eye Group. Updates are the responsibility of the patient and / or designee.

List below persons with whom sharing medical information is granted. Add any qualifiers or restrictions as needed. List in order of preference.

Emergency Contact: _____
First Middle Last

Relationship to patient: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

I give permission for information to be left on my answering machine. Please check all that apply.

Home Phone: _____ Cell Phone: _____

_____ Test Results

_____ Appointments

_____ Prescriptions

_✓_ Billing / Account information

I may revoke this authorization by contacting your office in writing,

Signed: _____ **Date:** _____

If Guarantor, relationship to patient _____