Authorization for Release of Information to Family Members

Patient Name _____ Date of Birth _____

Many of our patients allow family members such as their spouse, parents or children to call and request medical or billing information. While we are happy to provide this information when requested, under the requirements of HIPAA laws any patients over the age of 18 must provide written consent.

We understand your time is important so if you foresee that your Mom, Dad, Son, Daughter, caretaker, etc. may request a prescription, record or bill in your absence, please list their name below so we can get this information to them as quickly and easily as possible.

I authorize Liberty Lake EyeCare Center to release my medical and/or billing information to the following individual(s):

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

Signed_____ Date_____

Thanks for your cooperation!