

IdealEyes Optometry
2596 Reynolda Rd, Suite A
Winston-Salem, NC 27106

Consent to Release Protected Health Information to Specific Individuals



Patient: _____ DOB: _____

Due to HIPAA regulations, we no longer are allowed to release any medical information regarding your medical condition, diagnosis, treatment, or prognosis to any person without your consent.

You may designate a person or persons who are allowed to obtain this information, in your absence, by phone or in person.

If you have a Legal Guardian or Power of Attorney, we require that a copy of the legal document be on file with your records at IdealEyes Optometry.

It is important for our office to have on record your designated person/persons to whom we can release medical information. Please list below the appointed person/persons that you will allow to obtain this information.

You may release the following information:

Medical	Financial	Do not release to anyone other than me
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Release to:

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

(Practice Representative)

This document will remain effective indefinitely unless otherwise rescinded by written noted.