**Disclosure Form** Chart:


Name: _____
DOB: _____ Age: _____ Gender: _____
Date: _____ Office: _____

**Consent for Disclosure to Family Member and/or Personal Representative**

Please complete this form if you wish to give authorization to EYE PHYSICIAN ASSOCIATES, S.C. to speak with anyone other than yourself regarding your care with our office. Please note, HIPAA requires our office to have written consent from a patient before medical information is given to anyone not involved in the patient's care for purpose of treatment or billing.

**I give EYE PHYSICIAN ASSOCIATES permission to discuss the information contained in my medical and/or billing records to the following people:**

Name: _____ Relationship to Patient _____

Phone # _____ Email Address _____

Name: _____ Relationship to Patient _____

Phone # _____ Email Address _____

**PERMISSION TO LEAVE MESSAGE**

☐ I hereby agree that my EYE PHYSICIAN ASSOCIATES doctor may leave a message for me, at my home, work on my voicemail, answering machine or by email regarding my diagnosis information or test results.

☐ I understand that I may receive a copy of EYE PHYSICIAN ASSOCIATES Privacy Practices Notices upon my request.

☐ I understand that I can revoke these disclosures by sending a letter to my doctor terminating these permissions.

_____ _____
Signature Date