Office Use Only MRN:_____

THE REGIONAL EYE CENTER

Consent to Release Information

Name of Patient:_____ **Date of Birth:**_____

*Do you authorize **The Regional Eye Center** to leave messages regarding your care in the event that you cannot speak with **The Regional Eye Center** directly?* ☐ **Yes** ☐ **No**

*I have given permission to the Physicians and Staff of **The Regional Eye Center** to use or disclose my health information records with the following Recipient(s) that I have identified below:*

Name:_____ **Date of Birth:**_____

Phone #:_____ **Relationship to Patient:**_____
Emergency Contact: ☐ **Yes** ☐ **No**

Name:_____ **Date of Birth:**_____

Phone #:_____ **Relationship to Patient:**_____
Emergency Contact: ☐ **Yes** ☐ **No**

Name:_____ **Date of Birth:**_____

Phone #:_____ **Relationship to Patient:**_____
Emergency Contact: ☐ **Yes** ☐ **No**

Name:_____ **Date of Birth:**_____

Phone #:_____ **Relationship to Patient:**_____
Emergency Contact: ☐ **Yes** ☐ **No**

This is an indefinite consent form unless otherwise specified. I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that I may refuse to sign this authorization and the above-named office may not condition treatment on my signing this authorization.

_____ _____

Patient Signature or Authorized Representative **Date Sign**

If Authorized Representative, relationship to Patient _____