Walker Eye Care

Consent For Release Of Protected Health Information To Family

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care_____

_____

Check all that may apply:

☐ All my medical information to include:

Information necessary to schedule appointments for me

Lab or test results

Information necessary to provide, call in or pick up prescriptions for me

Information necessary to help my family members care for me

Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me

☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient of the Practice unless OR until I notify the Practice in writing of any changes.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

PATIENT ACKNOWLEDGMENT

I have been given the opportunity to read and review a copy of Walker Eye Care's Notice of Privacy Practices, Effective January 1st, 2013.

_____ _____

Signature of Patient or representative Date

_____

Print Name

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

_____

_____

_____

_____

For Walker Eye Care use only

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the Patient or the Patient's representative, please explain your efforts to obtain the acknowledgment and the reason you could not obtain it:

_____
_____
_____
_____