PACIFIC EYE ASSOCIATES

2100 Webster Street, Suite 214
San Francisco, CA 94115
Phone: (415) 923-3007
Fax: (415) 923-6586

Consent for Disclosure to Family Member and/or Personal Representative

Please complete this form if you wish to give authorization for our office 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.

Patient Name _____ Date of Birth _____/_____/_____

I, _____ agree to allow the following individuals to receive information related to my medical care. Therefore, I give my permission for Pacific Eye Associates to disclose my personal medical information to the following individual(s).

Name: _____ Relationship to Patient: _____
Phone #: _____ Email Address: _____

Name: _____ Relationship to Patient: _____
Phone #: _____ Email Address: _____

Consent to leave personal medical information on voicemail or email

The practice may leave test results and information regarding my care by voicemail at this phone number: _____

The practice may send information regarding my test results and information regarding my care to the following email address: _____.

I understand that this consent may be revoked by me at anytime by written notice to the practice. I am aware that a copy of this signed disclosure will be kept as part of my medical record.

_____ _____
Patient's Signature Date