

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's care for purpose of treatment or billing.	
Patient Name	Date of Birth/
I,a to my medical care. Therefore, I g personal medical information to the	gree to allow the following individuals to receive information related ive my permission for Pacific Eye Associates to disclose my e following individual(s).
Name:	Relationship to Patient:
Phone #:	
Name:	Relationship to Patient:
Phone #:	
Consent to leave per	sonal medical information on voicemail or email
The practice may leave test results number:	s and information regarding my care by voicemail at this phone
The practice may send information the following email address:	regarding my test results and information regarding my care to
	be revoked by me at anytime by written notice to the practice. Id disclosure will be kept as part of my medical record.
Patient's Signature	