PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the results of tests, procedures and financial information. Under the requirements for H.I.P.A.A., if a patient is over 18 years old, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic tests and or/financial information released to any other persons you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Palatine Vision Center(PVC) to release my records and any information requested to the following individuals.

1. _____ **Relation to Patient:** _____

2. _____ **Relation to Patient:** _____

3. _____ **Relation to Patient:** _____

4. _____ **Relation to Patient:** _____

Authorization Regarding Messages
(please check all that apply)

___ I authorize PVC to leave a detailed message on my home or cell number regarding appointments

___ I authorize PVC to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

___ I authorize PVC to leave a message with anyone who answers the phone

___ Messages may only be left with _____

_____ _____

Patient Name (PRINT) Date

_____

Patient Signature

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