

Legacy Eye Care

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

**** For Messages****

Please call my home my work my cell Number: _____

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Signature: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____