Patient MRN _____

METROPOLITAN EYE CENTER

PATIENT PHI RELEASE FORM

I, _____, under any circumstances hereby authorize the release of
(Please Print — Patient/Guardian)

medical and optical information to the following as indicated below.

In the event I am unable to make it to the office, they may obtain anything on my behalf (prescriptions, samples, etc.) and, make or change appointments if I am unable to do so.

Information may be released to the following: (For example, spouse, children, parent, caregivers, friends)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

In addition:

May we leave a message on your answering machine, or with someone at home telephone number ☐Yes ☐No

May we send a reminder post card for appointments and diagnostic tests ☐Yes ☐No

Family/Primary Care Physician:

_____

Telephone #:

_____

_____ _____

Patient/Guardian Signature **Date**

Please note: With Federal regulations regarding "Protected Health Information", we may require identification from the above persons as a precaution in protecting your health information.

09/2018