

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 voice mail, answering machine, Yes No
or with someone at telephone number provided by you

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

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.