AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION HIPAA

Compliance Privacy Laws of the Federal Government require that we ask you to review and answer the following questions listed below.

Patient's Name: _____

May we leave messages/detailed medical information on voicemail or text message at either of these phone numbers?

□ Yes □ No Home Phone: _____

□ Yes □ No Cell Phone: _____

May we leave messages/detailed medical information by email?

□ Yes □ No Email address: _____

May we contact you at your place of employment?

□ Yes □ No If so, may we leave a message?

□ Yes □ No If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____
Phone Number: _____ Alternate Number: _____

Do you have a person who is your Power of Attorney for medical purposes?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____
Phone Number: _____ Alternate Number: _____

I hereby authorize James Barnett JR. O.D, Barnett Vision Clinic LLC, to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above. I have reviewed this Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ **Date**: _____