Callahan Eye Clinic, PC

AUTHORIZATION TO RELEASE / DISCUSS PROTECTED HEALTH INFORMATION

Due to the **HIPAA Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

PATIENT NAME: _____

❖ **MAY WE LEAVE MESSAGES AND/OR DETAILED MEDICAL INFORMATION ON VOICEMAIL AT EITHER OF THESE PHONE NUMBERS?**

☐Yes ☐No Home Phone: _____ ☐Yes ☐No Cell Phone: _____

May we contact you at work? ☐Yes ☐No **May we leave a message?** ☐Yes ☐No

If yes: Work Phone: _____ Extension: _____

❖ **AUTHORIZATION TO DISCUSS YOUR MEDICAL CONDITION**

Occasionally, it may be necessary for your doctor or other employees of Callahan Eye Clinic, PC to discuss your medical condition and/or your account with others, thereby releasing Protected Health Information. Do you have any particular person or family members that you authorize to receive and discuss this information regarding your personal health (general information, prescriptions, surgical information, insurance issues and billing)?

Check One: ☐YES - ALL Family Members ☐NO - Do NOT discuss with anyone else.

☐YES - but ONLY those individuals listed below:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? ☐*Yes* ☐*No*

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? ☐*Yes* ☐*No*

❖ **NOTICE OF PRIVACY PRACTICES**

I understand and acknowledge that I have received and reviewed the "Notice of Privacy Practices" for Callahan Eye Clinic, PC. I also understand that it is posted in their waiting room with multiple printed copies available for me to review. Additional copies of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

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Submit Form