Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request information regarding appointments, prescriptions, test results, and financial information. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Barrow Eye Center to release the records of _____ and/or discuss any information to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____
5. _____ Relation to Patient: _____
6. _____ Relation to Patient: _____

_____
Patient/Guardian Name (please print)

_____ _____
Patient/Guardian Signature Date