AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

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

Name:

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

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

May we contactyou at your place of employment? Yes No

If so, may we leave a message Yes No If yes, Work Phone _____ Ext. _____

Do you have any particular person or family member 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:** _____

Is this person your Power of Attorney for Medical purposes? Yes No

Name: _____ **Relationship:** _____

Phone Number: _____ **Alternate Number:** _____

I **hereby authorize** KOZIOL -THOMS EYE ASSOCIATES **to obtain and/or release any and all pertinent information with my primary care physician or specialist.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Koziol - Thoms Eye Associates Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witnessed By: _____