PAK FAMILY EYE CARE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their parent(s), grandparents, guardians or other to call and discuss medical information, request prescriptions, medical records, and results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release selected information to individuals listed below.
I or legal representative of the patient authorizes representatives of Pak Family Eye Care to share and/or release information to:

1) Name:_______________________________________ Relationship _____________________
Check all that apply:

- ☐ Regarding appointment time & Date
- ☐ Invoice, Billing and Insurance information
- ☐ Discuss medical care, and issue or concern
- ☐ Request medical records / Prescriptions
- ☐ All of the above

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2) Name:_______________________________________ Relationship _____________________
Check all that apply:

- ☐ Regarding appointment time & Date
- ☐ Invoice, Billing and Insurance information
- ☐ Discuss medical care, and issue or concern
- ☐ Request medical records / Prescriptions
- ☐ All of the above

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3) Name:_______________________________________ Relationship _____________________
Check all that apply:

- ☐ Regarding appointment time & Date
- ☐ Invoice, Billing and Insurance information
- ☐ Discuss medical care, and issue or concern
- ☐ Request medical records / Prescriptions
- ☐ All of the above

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I understand that I have the right to change this authorization, in writing, and any time by sending a written notification to this office. I have read/understand Pak Family Eye Care's Notice of Privacy Practices (HIPAA) form:

______________________________ ____________________________ __________________
Name of Patient (Print) Signature of Patient or Representative Today's Date

*If you are the patient's representative please fill out below.

___________________________ __________________________ ______________________
Name of Representative (Print) Relationship to patient Representative's DOB