PATIENT INFORMATION AND MEDICAL RECORD RELEASE AUTHORIZATION

Emerald City Eye Care, LLC

PATIENT INFORMATION **Today's Date:** _____ / ____ /_____

Name: Last _____First _____M.I. ____

DOB: _____ / ____ /_____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____State:_____Zip Code: _____

RELEASE OF INFORMATION

Please tell us whom we are allowed to discuss/disclose your personal health information.

Name: _____ Relationship: _____

Contact Information: _____

Name: _____ Relationship: _____

Contact Information: _____

Name: _____ Relationship: _____

Contact Information: _____

In compliance with *HIPAA* regulations, we are required to have confirmation that you have been offered a copy of **Emerald City Eye Care's** Notice of Privacy Practices, or an opportunity to review a copy of **Emerald City Eye Care's** Notice of Privacy Practices.

If at any time you wish to change the information provided on this form, please ask for a new form prior to your appointment so your chart can be updated. Please do not hesitate to ask if you have any questions regarding HIPAA regulations or **Emerald City Eye Care's** Office Policies.

My signature below authorizes the release of medical information from **Emerald City Eye Care** to the above named.

Patient Print Name: _____

Patient Signature: _____ Date: ____ / ____ /____