CLARITY
EYE CENTER
personalized eye care

Patient Name_____

Disclosure to Friends, Caregivers, and/or Family Members

Do you want to designate a family member or other individual with whom the provider may discuss your medical condition? If yes, whom?

At the request of the individual: I give permission for my Protected Health Information to be disclosed for purpose of communicating results, findings, care decisions, and financial information to the people listed below:

Name:_____ Relationship_____ Contact Number_____

Name:_____ Relationship_____ Contact Number_____

Name:_____ Relationship_____ Contact Number_____

- This authorization will expire one year from your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than one year from your last signature date: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Patient or Responsible Party Date