Harrel eyecare

Consent to disclose medical and payment information

Patient Name: _____ Date of Birth: _____

Please CHECK one of the following:

_____ I give my permission to Harrel Eyecare doctors to disclose my Protected Health Information or payment to me AND the following friends or family:

NAME: _____RELATION: _____

NAME: _____RELATION: _____

NAME: _____RELATION: _____

NAME: _____RELATION: _____

OR

_____ I request that all my Protected Health Information be disclosed ONLY to me and no other friends or family.

_____ _____

Signature of patient or guardian Date

_____

Relation if not signed by patient