

Authorization for Release of Information to Family Members

Patient Name:	DOB:
to call and request medical HIPAA we are not allowed to consent If you wish to have	family members such as their spouse, parents or other or billing information. Under the requirements of to give this information to anyone without the patient's e your medical or billing information released to family is form. Signing this form will only give information to below.
I authorize Advanced Eyec billing information to the fo	are, LLC to release my medical and /or ollowing individuals(s):
1	Relation to Patient:
2	Relation to Patient:
3	Relation to Patient:
Patient Information	
	right to revoke this authorization at any time and inspect or copy the protected health information to
	mation disclosed to any above recipient is no longer state law and may be subject to redisclosure by the
You have the right to re	evoke this consent in writing.
Signature:	Date:

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