ELKIN
EYE CARE

Dr. Kala Brewer

HIPAA Release

Release of Information

I hereby authorize Elkin Eye Care to release such medical and billing information as may be required by any insurance company concerned with payment of benefits for me (or my dependent child). I further authorize Elkin Eye Care to release medical information to any facility or physician to whom I (or my dependent child) am/are referred. These authorizations shall remain in effect until I provide written notice revoking them.

Privacy Notice

I acknowledge that a written copy of Elkin Eye Care Privacy Notice is available as required by the Health Portability and Accountability Act (HIPPA).

_____ _____

Signature of patient or responsible party Date

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Under the HIPAA regulations we are not allowed to give any medical or billing information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must complete this form. Signing this form will only give consent to release this information to the family members indicated below.

You have the right to revoke this consent in writing.

I authorize/allow Elkin Eye Care to release my medical and/or billing information to the following individual(s):

1 _____ Relation to patient: _____ Phone #: _____

2. _____ Relation to patient: _____ Phone #: _____

3. _____ Relation to patient: _____ Phone #: _____

4. _____ Relation to patient: _____ Phone #: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____