

## **Authorization to Discuss Protected Health information**

Print Patient's Legal Name		(office only) MRN#	
Previous Names		Birth Date/	
1. Phone Messages			
My care team may leave information <b>on</b>	my voicemail or answe	ering machine at these numbers:	
Cell:	lome:	Work:	
2. Person-to-Person Communication			
To help with my care or billing, my care to	eam may share informa	ation with these people:	
First name, last name	Relationship to me	Best contact number	
Please share:   Scheduling information	☐ Medical Informat	tion	
First name, last name	Relationship to me	Best contact number	
Please share: $\square$ Scheduling information	☐ Medical Informat	tion	
First name, last name	Relationship to me	Best contact number	
Please share:   Scheduling information	☐ Medical Informat	tion	
records.		access to Northwest Eye Clinic's electronic medical ve unless I specify below, information that I don't want	
Date Signature of	of natient or authorized ners	Son Authorized person's authority to sign	

THIS AUTHORIZATION DOES NOT HAVE AN END DATE.

IT WILL STAY IN EFFECT UNTIL CHANGED OR CANCELLED BY THE PATIENT OR AUTHORIZED PERSON