Authorization to Discuss Patient's Medical Information

Patient's Name: _____

Have given the staff at the Taustine Eye Center permission to discuss medical information with the following person(s):

Name: _____Relationship_____

Name: _____Relationship_____

Name: _____Relationship_____

This information could include appointment type, times, and dates, as well as scheduling appointments for you, prescription refills, test results, medical instructions or surgery date, time and location.

The Taustine Eye Center has my permission to leave a message on my answering machine in the event that I cannot be reached at home. YES_____ NO_____

The Taustine Eye Center has my permission to contact me at my place of employment. YES____ NO_____

Practice Requirements

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing to Practice's legal duties and privacy practices with respect to you PHI.
- Under the Privacy Rule, may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

This Notice is in effect as of 04/15/2003.By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and agreement to its terms.

PATIENT SIGNATURE_____ Date_____