AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the HIPPA Compliance Privacy Laws of the Federal Government, it is mandatory that we ask you to review and answer the following questions listed below.

PATIENT: _____ DOB: _____

May we contact/leave messages/detailed medical information on voicemail at any of these phone numbers?

Home Phone: _____ Yes □ No □

Cell Phone: _____ Yes □ No □

Work Phone: _____ Ext: _____ Yes □ No □

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general, surgical, and billing)?

Yes □ No □ If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize Advanced Vision, PC to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed Advanced Vision's Notice of HIPPA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witnessed By: _____ Date: _____