LAKESIDE EYE
ASSOCIATES

Authorization for Release of Information to Family Members and Notice of Privacy Practices HIPAA Acknowledgment

Patient Name_____ Date of Birth_____Last 4 SSN:_____

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, prescriptions, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, prescriptions and/or financial information released to any family members you must sign this form. Signing this form will only give information to family members listed below.

I authorize Lakeside Eye Associates to release my medical and/or billing information to the following individual/s.

1. _____Relation to Patient:_____
2. _____Relation to Patient:_____
3. _____Relation to Patient:_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or obtain copies of the protected health information to be disclosed.

I understand that information disclosed to any above recipients is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

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I also acknowledge available paper copies at my request and/or link to www.lakesideeyes.com for a complete HIPPA Privacy Agreement for Lakeside Eye Associates.

Signature:_____ Date:_____