THE
Vision Care
CENTER

Authorization to Verbally Release Protected Health Information to Family Members or Personal Representatives

I _____, hereby authorize The Vision Care Center
(name of patient)

- ❑ Physician / or nursing staff of: _____
  (name of physician)
- ❑ Business Services
- ❑ Other _____

to verbally share confidential information to the following individuals concerning:

- ❑ All matters relating to my health care including mental health, alcohol & drug treatment, and communicable diseases; or
- ❑ Only my health care problems and treatment relating to_____

_____
(describe the conditions for which information may be released)

_____
(name & relationship to patient)

_____
(name & relationship to patient)

_____
(name & relationship to patient)

This authorization may be revoked at any time by notifying The Vision Care Center in writing, but the revocation will not effect any actions which have been taken prior to the receipt of the revocation. I understand that this authorization will expire upon my written request for change or revocation, directed to The Vision Care Center.

I understand and acknowledge that the confidential health care information disclosed to the above named individuals may be subject to redisclosure by those individuals and may no longer be protected by federal privacy regulations.

_____ _____
Patient's Signature Date of Birth

_____ _____
Witness Today's Date

Release of PHI to Family Members or Personal Representative