CHESTER COUNTY
EYE CARE

(610) 696-1230
CHESTERCOUNTYEYECARE.COM

PATIENT DISCLOSURE AUTHORIZATION (HIPAA)

Date: ______________________

Patient Name: ____

With your permission, we can provide information to you in a variety of ways. Please indicate agreement with the following by checking all that apply:

☐ It is acceptable for you to leave information on my answering machine, including appointment reminders.

*Phone Number: __________________________

☐ I do not want you to speak with any family members or friends regarding my condition.

☐ It is acceptable for you to speak with only the following family members/friends regarding my condition: *(please check all that apply)*:

Name:_____________________ Phone_________________ Relationship: ☐ Spouse ☐ Sibling ☐ Child ☐ Friend ☐ Parent ☐ Other

Name:_____________________ Phone_________________ Relationship: ☐ Spouse ☐ Sibling ☐ Child ☐ Friend ☐ Parent ☐ Other

Name:_____________________ Phone_________________ Relationship: ☐ Spouse ☐ Sibling ☐ Child ☐ Friend ☐ Parent ☐ Other

Name:_____________________ Phone_________________ Relationship: ☐ Spouse ☐ Sibling ☐ Child ☐ Friend ☐ Parent ☐ Other

Name:_____________________ Phone_________________ Relationship: ☐ Spouse ☐ Sibling ☐ Child ☐ Friend ☐ Parent ☐ Other

Any additional persons, please see the Front Desk.

It is the patient's responsibility to notify the office staff of any changes to this Authorization.

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Signature

Office Use:
MRN: