HIPAA and Release of Information Form

Patient Name: ______________________________ **Date of Birth:** ______________________

I acknowledge that I was offered and/or received a copy of Teresa Seim, O.D., Mattawan Family Eye Care's Notice of Privacy Practices ☐

The purpose of this section is to provide our patients with an opportunity to permit verbal release of Protected Health Information (PHI) in the following ways. (This does not authorize the release of copies of medical records).

1. **Permission to verbally discuss PHI with family members/ caregiver**
   I herby authorize medical providers and personnel of Mattawan Family Eye Care to discuss my protected health information with the following person(s).

   Name: ______________________________

   Primary Phone: ______________________ Relationship: ______________________

   Please indicate the information that is allowed to be discussed with the person listed above:

   Billing/ Insurance Medical Information

   Name: ______________________________

   Primary Phone: ______________________ Relationship: ______________________

   Please indicate the information that is allowed to be discussed with the person listed above:

   Billing/ Insurance Medical Information

   (OR) ☐ **I decline**. Please do not discuss my care with anyone other than as allowed by HIPPA regulations.

2. **Permission to leave messages**
   Please check YES or NO for the following statements. By indicating YES, Mattawan Family Eye Care will leave a voicemail or answering machine messages at your home, work, or emergency contact on file that may include your protected health information and that may be overheard by others not involved in your care.

Place	Callback/Message		Detailed Message	
Home	Yes	No	Yes	No
Work	Yes	No	Yes	No
Emergency Contact	Yes	No	Yes	No

______________________________ ______________________________

Signature of Patient or Personal Representative Printed Name of Patient or Personal Representative

______________________________ ______________________________

Date Relationship to Patient

This information will remain in effect until revoked or changed.

This Form is not valid unless signed and dated.