Allisonville Eye Care Center

Authorization to Discuss Your Information with Family or Caregiver

To comply with the new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss information about you with anyone else including your family, children, and/or caregivers. With your authorization, we will be able to discuss your case, answer questions, leave detailed messages, or contact for other reasons the person(s) listed below. This authorization is optional, and you can withdraw it at any time.

Emergency Contact - Required:

Name:_____

Relationship:_____

Phone:_____

Authorization to share information with the emergency contact. ( ) Yes ( ) No

Both parents are to be listed if we are authorized to share information regarding a minor.

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Phone:_____ Phone:_____

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Phone:_____ Phone:_____

( ) I do not authorize the release of my information to others (this excludes medical professionals).

Permission to text ( ) Yes ( ) No

Please call ( ) my home_____ ( ) my work_____ ( ) my cell phone number_____

If unable to reach me: ( ) you may leave a detailed message

( ) please ask me to return your call

Preferred day and time to be contacted _____

Patient's printed Name: _____

Patient's (Guardian's) Signature: _____ Date: ____/____/_____

Updated 10/20/25