Permission to Discuss Protected Health Information with Family and Friends

--Completion of this form is optional—

Patient Name:	Date of Birth:		
Patient Street Address:	City	State	Zip
Phone number:			

I give permission for Jarrettsville Family Eyecare to share the information I have checked with family, friends, or others that I have identified below as being involved in my health care, care coordination or payment of my health care. (Check all boxes that apply). This form does not authorize releasing copies of my records.

- ☐ Scheduling/Appointment information
- ☐ Medical information, including symptoms, diagnosis, medications and treatment plan
- ☐ Picking up, dropping off, and/or mailing glasses and/or contact lenses
- ☐ Billing and payment information
- ☐ Test results

Jarrettsville Family Eyecare has my permission to discuss the above information with the following family member, friend, or other person/people (list up to two people). This information is directly relevant to their involvement in my health care (or payment for that care).

Name (1):	Phone number:	Relation:
Name (2):	Phone number:	Relation:

I understand that in certain situations Jarrettsville Family Eyecare may speak with other individuals who are involved in my care or payment of that care, if permitted by law, which may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where Jarrettsville Family Eyecare has already made disclosures in reliance upon this request. **I understand this permission remains in effect until the time I revoke in writing.** If an updated permission form is received, the new version will automatically revoke the previous version on file.

Signature of Patient/Authorized Representative: _____ Date: _____

If other than patient, state relationship and authority to sign: _____