ASSOCIATED EYECARE

Authorization to Verbally Discuss Protected Health Information

**Note: This form is optional. In order for this form to be valid, all information must be completely filled out.*

Patient Name: _____ Date of Birth: ___/___/_____

I hereby give permission for Associated Eye Care and affiliates to verbally discuss the following medical and billing information about me (check all that apply):

- Scheduling/appointment information
- Medical information, including my symptoms, diagnosis, medications, and treatment plan
- Lab/Test results
- Billing and payment information
- All information
- Other: _____

Associated Eye Care and affiliates have my permission to discuss the above information with:

Name	Phone Number	Relationship to Patient

I understand that I may cancel this permission at any time by notifying Associated Eye Care in writing; however, canceling permission will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

_____ _____

Signature of Patient or Parent/Legal Guardian *Date*