

# Allisonville Eye Care Center

10967 Allisonville Road Suite 102 Fishers, IN 46038

Phone (317) 577-0707 Fax (317) 577-1567

## 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.

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

### Messages

Please call ( ) my home \_\_\_\_\_ ( ) my work \_\_\_\_\_ ( ) my cell phone number \_\_\_\_\_

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

( ) please leave a message asking me to return your call

( ) \_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_