PROTECTED HEALTH INFORMATION RELEASE FORM

It is the office policy of Atlantis Vision Center not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from your circumstances (for example, if you bring a family member or friend into the examination room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996, as amended in 2013. If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the box marked none. By signing below, you authorize the following people to receive information regarding your treatment or care.

I authorize the person(s) listed below to have access to any of my protected health information, including HIV, drug and alcohol abuse and psychiatric records. Atlantis Vision Center is permitted to share with them test results and any other information contained in my health record. For copies of medical records, I understand that I will need to sign a separate authorization.

List below those individuals that you wish to receive your protected health information:

Patient Name:________________________ Relationship:____Self_____ Phone:______________

Full Name:___________________________ Relationship:____________ Phone:______________

Full Name:___________________________ Relationship:____________ Phone:______________

Full Name:___________________________ Relationship:____________ Phone:______________

□ **NONE**

In addition to those individuals listed above, I request that you may also notify me of test results, appointment confirmations, and other information related to my health in the following manner:

Leaving messages on the following numbers:

1) Home Phone:______________________________ 3) Work Phone:______________________________

2) Cell Phone:______________________________ 4) Email:____________________________________

I understand that it is my responsibility to update Atlantis Vision Center with any changes in the above listed contact numbers. I understand that this authorization will remain in effect until it is revoked by me in writing.

□ I am the patient

□ If the patient is under 18 years of age, I am the patients legal guardian.

□ I am the legal guardian or power of attorney holder for the patient.

Name:____ Date:______________________________

Signature:______________________________________ Witness:___________________________

I acknowledge that I have been made aware of Atlantis Vision Center's HIPAA Policy and Notice of Privacy Practices clearly on display in the reception area of said practice.