mountainvieweyes.com

AUTHORIZATION TO RELEASE INFORMATION VERBALLY

Patient Name: ______________________________ Date of Birth: ________________

Social Security #: ____________________

Information to be Released/Discussed:

- ❑ Medical Information
- ❑ Billing Information
- ❑ Diagnosis/Treatment Plans
- ❑ Prescriptions/Refills
- ❑ Appointment Information
- ❑ All Information/Records

- ❑ Specific Date(s) of Service: ____________________
- ❑ All Dates of Service

- ❑ Can Make Changes
- ❑ Cannot Make Changes

Individual who is released for above permissions (personal representative):

Name: ________________________ Relation to Patient: ________________________

In accordance with HIPAA Law, I, the above-listed patient, hereby authorize the staff and physicians at Mountain View Eye Center to release information in the form of verbal discussion with the individual named for the specified dates of service or until this authorization expires or is revoked. I understand that, in order for the above-named individual to acquire any written documents regarding my health or my account, I will need to fill out a separate release of information form for specified dates of service. I acknowledge by my signature that I understand that, although I am not required to release my information, I am giving my consent to do so. This authorization expires in three years or on ____________________, whichever is sooner. I understand that I may revoke this authorization in writing at any time before it expires, except for that information which has already been released with consent and prior to my revocation.

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Signature of Patient or Legal Guardian Date