CARLINVISION
Advanced eye care with a home-town touch
2377 LENORA CHURCH ROAD
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CARLINVISION.COM
FACEBOOK.COM/CARLINVISION

Authorization to Receive/Release Health Information

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____ Date of Birth: _____
(Please Print)

May we leave message/detailed medical information on voicemail at either of these phone numbers?

☐ Yes ☐ No Home Phone: _____ ☐ Yes ☐ No Cell phone:_____

May we contact you at your place of employment? ☐ Yes ☐ No

If so, may we leave a message? ☐ Yes ☐ No Work Phone: _____ Extension:_____

Do you have a particular person or family member(s) that you authorize to receive or discuss information regarding your personal health information (general information, surgical and billing)? ☐ Yes ☐ No

Name: _____ Relationship: _____ Phone: _____
(Please Print)

Name: _____ Relationship: _____ Phone: _____
(Please Print)

I hereby authorize CarlinVision to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed the Notice of Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Name: _____
(Please Print)

Patient Signature: _____Date: _____