St. Cloud Eye Care

Release Form

In order to help us stay within the guidelines of HIPPA, please list below any person/persons that you authorize us to disclose your Protected Health Information with, including billing information and dispensing of prescriptions. Please provide all information requested.

Name: _____ Phone number:_____

Date of Birth: _____ Relationship to patient:_____

Name: _____ Phone number:_____

Date of Birth: _____ Relationship to patient:_____

Name: _____ Phone number:_____

Date of Birth: _____ Relationship to patient:_____

(Patient Information)

Patient Name: _____ Date of birth: _____

SSN: _____ Phone number: _____

This authorization will continue until it is withdrawn, by me (the patient), in writing.

Patient Signature: _____ Date: _____

(Office use only)

Use this space for consent withdraws only: Need written letter from patient.

_____ _____

Date consent revoked Staff Signature