CENTRAL VALLEY EYE MEDICAL GROUP, INC.
GENERAL OPHTHALMOLOGY/SUBSPECIALTY CARE

# 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: _____

May we leave messages/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

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, financial, surgical and billing)?

□ Yes □ No If yes, please provide:

**Name**: _____ Relationship: _____

Phone Number: _____
Alternate Number:_____

Is this person your Power of Attorney for medical purposes? □ Yes □ No

# CENTRAL VALLEY EYE MEDICAL GROUP, INC.

GENERAL OPHTHALMOLOGY/SUBSPECIALTY CARE

**Name:** _____ Relationship:_____

Phone Number: _____
Alternate Number: _____

Is this person your Power of Attorney for medical purposes? □ Yes □ No

I hereby authorize Central Valley Eye Medical Group Inc., 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 Central Valley Eye Medical Group, Inc., Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____

Date: _____

WITNESSED BY: _____