314-367-1181
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THE RETINA INSTITUTE

Authorization of Communication to Designee(s)

Patient Name _____ Acct # (Office Use Only) _____

Date of Birth _____ Social Security Number _____

Pharmacy Name _____ Pharmacy Address _____

Release of Information to Family/Friends and Caregivers. Our practice may release your Protected Health Information, **with your written authorization**, to a friend or family member that is involved in your care, or to someone who assists in taking care of you. If you have a home health aide, one of your [adult] children, or someone else accompany you for your visit with one of our providers for management of a medical problem; these individuals may have access to your medical and billing information. For designees that you may ask to act on your behalf, we require you to provide us a signed authorization that details the following information of any and all designees:

Designee Name _____ Relationship _____

Phone Number _____ Emergency Contact ☐

Designee Name _____ Relationship _____

Phone Number _____ Emergency Contact ☐

I understand that I may revoke this authorization at any time through written notice.

Signature _____ _____
(Patient, Parent, or Legal Guardian) (Today's Date)

Separate authorization must be given before information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, mental health treatment, HIV testing and AIDS diagnosis or treatment** can be discussed. I understand that I may revoke this authorization at any time through written notice.

Signature _____ _____
(Patient, Parent, or Legal Guardian) (Today's Date)