Koziol – Thoms Eye Associates

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF 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.

Patient Name: _____ Date of Birth: _____

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 yes, may we leave a message? ☐ Yes ☐ No

If yes: Work Phone: _____ Extension: _____

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

☐ Yes ☐ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Phone: _____

Is this person your Power of Attorney? ☐ Yes ☐ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Phone: _____

I hereby authorize, KOZIOL-THOMS EYE ASSOCIATES to obtain and/or release any and all pertinent information with my primary care physician, specialist, and insurance carrier.

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

I have reviewed Koziol-Thoms Eye Associate's Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witnessed by: _____

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