THE EYE INSTITUTE FOR MEDICINE & SURGERY

1995 W NASA Boulevard Melbourne, FL 32904 | 150 South Woods Drive Rockledge, FL 32955 | 5055 Babcock Street N.E. Palm Bay, FL 32905 | 1709 Garden Street Titusville, FL 32796

Phone: 321-722-4443 * www.seebetterbrevard.com * Fax: 321-722-2334

PROTECTED HEALTH INFORMATION RELEASE FORM

It is the office policy of The Eye Institute for Medicine & Surgery not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the examination room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996, as amended in 2013. If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, you will need to complete a new copy of this form.)

I authorize the person(s) listed below to have access to any of my protected health information, including HIV, drug and alcohol abuse and psychiatric records. The Eye Institute is permitted to share with them test results and any other information contained in my health record. For copies of medical records, I understand that I will need to sign a separate authorization.

List below those individuals that you wish to receive your protected health information:

Patient Name: _____ **Relationship:** Self **Phone:** _____

Full Name: _____ **Relationship:** _____ **Phone:** _____

Full Name: _____ **Relationship:** _____ **Phone:** _____

Full Name: _____ **Relationship:** _____ **Phone:** _____

☐ **NONE**

In addition to those individuals listed above, I request that you may also notify me of test results, appointment confirmations, and other information related to my health in the following manner:

Sending me email at: _____

Leaving messages on the following numbers:

1) HOME PHONE:_____ 3) WORK PHONE:_____
2) CELL PHONE: _____

Or you may reach me the following ways: _____

I understand that it is my responsibility to update The Eye Institute with any changes in the above listed contact numbers. I understand that this authorization will remain in effect until it is revoked by me in writing.

☐ I am the Patient
☐ If the patient is under 18 years of age, I am the patient's legal guardian.
☐ I am the legal guardian or power of attorney holder for the patient.

Name: _____ **Date**: _____

Signature: _____

Witness: _____

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PATIENT'S ACKNOWLEDGEMENT & CONSENT TO:
"HIPAA: NOTICE OF PATIENT'S RIGHTS & PRIVACY PRACTICES,"
"PATIENT INFORMATION & FINANCIAL RESPONSIBILITIES," "VISION PLAN INSURANCE POLICY," & "ADVANCED DIRECTIVES."

By my signature below, I hereby acknowledge that I have received the following documents:

1. HIPAA: Notice of Patient's Rights & Privacy Practices
2. Patient Information & Financial Responsibilities
3. Vision Plan Insurance Policy
4. Protected Health Information Release Form
5. Advanced Directives Policy

I understand that I am ultimately responsible to make payment for all services provided to me by any of the physicians of Florida Eye Consultants, Inc., Eye Institute Surgery Center, LLC, The Center for Hearing Improvement at the Eye Institute, d/b/a The Eye Institute for Medicine & Surgery. I understand that the practice may condition treatment upon execution of this consent and I agree to abide by all of the related policies of Florida Eye Consultants, Inc., Eye Institute Surgery Center, LLC, The Center for Hearing Improvement at the Eye Institute, d/b/a The Eye Institute for Medicine & Surgery. I understand that I may revoke this consent in writing at any time.

- ☐ I am the Patient
- ☐ If the patient is under 18 years of age, I am the patient's legal guardian.
- ☐ I am the legal guardian or power of attorney holder for the patient.

Name: _____ **Date**: _____

Signature: _____

Witness: _____

This acknowledgement page should be retained in the patient's record.
If acknowledgement could not be obtained from patient, the reasons must be documented below.

I have received verbal and written notice of my patient rights and responsibilities prior to my procedure.

☐ Yes ☐ No _____Patient Initials Date_____