AUTHORIZATION TO RELEASE HEALTH INFORMATION

Last Name: _____ First Name: _____ MI:_____

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.

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 text you for reminders? □ Yes □ No

May we contact you via email for scheduled appointments or to notify you that your glasses/contacts are in?

□ Yes □ No Email: _____

By signing this form, I hereby authorize Horizon Eye Care Group, P.C. to provide information regarding appointments and materials via email or text as noted above. I also consent to voicemails being left at the numbers I have provided. I may decline these authorizations by checking "no" on the boxes above. I understand that Horizon Eye Care Group, P.C. has obtained this authorization in accordance with the HIPAA Privacy Regulation and will not disclose my contact information to any third parties. If I wish to change the status of this disclosure, I will notify Horizon Eye Care Group, P.C. in writing at which time this authorization will become null and void.

In the course of providing you medical treatment and services, we may need to communicate with one of your family members, friends, or other persons known to you. Please specifically identify the person(s) who may receive your personal health information (general information, surgical, and billing). If they are not listed on this form, they will be allowed to obtain any information regarding your services in our practice.

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

I acknowledge that I have received and reviewed Horizon Eye Care Group, P.C.'s Notice of Privacy Practices for protected health information. I have reviewed the aforementioned information and provide my consent regarding any and all issues as stated above.

Patient Signature: _____ Date: _____

Witness Signature (*for internal use only)*:_____ Date: _____