Idaho Retina Center PLLC

From time to time we may have to contact you on the phone or we may receive a call from your family member or caregiver. In addition, groups such as nursing facilities and transportation services will contact us to confirm appointment times. Please let us know your wishes with regards to whom we may speak with about your upcoming appointments, test results, or exam findings. By filling and signing this form,you are giving us the permission to speak with the following individuals about your Protected Health Information (PHI).

Name	Relationship	We may discuss the following:
		☐ Your Appointment Information (Date, Time, Location and etc) ☐ Your Test Results ☐ Your Exam Findings ☐ Any Billing Questions ☐ Other
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If you wish to add or remove someone from this list, we ask you to please inform us of this decision as your earliest convenience.

It is entirely your decision whether or not to sign this form. We will not refuse to treat you if you choose not to sign. You may always revoke your signature later by sending a written request to our office at Idaho Retina Center PLLC at 901 N. Curtis Rd, Suite 302, Boise, ID 83706

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described on this form.

Patient (or legal guardian) signature: ______________________________ **Date:** ____________________

Printed Name: ____

If you are the legal representative of the patient that you are signing for, please describe your relationship to the patient and the source that give you legal authority to sign this form. If you are a power of attorney, please provide a copy to the clinic.

Relationship to the patient: ____________________ **Printed Name:** ______________________________

Source of authority: ____________________ **Witness:** ______________________________

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Authorization for Release of Identifying Health Information

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I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described on this form.

Patient (or legal guardian) signature: ______________________________ Date: ____________________

Printed Name: ______________________________