Cookeville Eye Specialists & Laser Center

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (please print): _____ **Date of Birth:** _____

This form does not apply to other physicians in connection with your ongoing care, insurance companies in connection with billing, state or federal healthcare agencies, or law enforcement agencies (which are allowed by federal law), and workers compensation agencies. We cannot release ANY of your medical information to any person or organization (including family members, spouse, etc) unless you list their names below.

I give permission to Cookeville Eye Specialists to discuss the following medical and billing information about me **(check all that apply)**:

- ☐ Scheduling/Appointment Information
- ☐ Medical Information (including symptoms, diagnosis, medications and treatment plan)
- ☐ Laboratory/Test Results
- ☐ Financial Details/Payment Information
- ☐ All of the Above
- ☐ Other: _____

Cookeville Eye Specialists has my permission to discuss the above information with:

Name	Phone Number	Relationship to Patient

I understand that I may revoke or terminate this permission at any time by submitting a written revocation to Cookeville Eye Specialists. I will contact Cookeville Eye Specialist's Privacy Contact in writing to terminate the authorization.

- ☐ This authorization expires:
- ☐ No expiration date
- ☐ Date specified ____ / ____ / ____ - unless revoked or terminated in writing by you or your patient personal representative.
- ☐ I decline permission to discuss medical information

_____ _____ _____

Signature of Patient/Guardian | Date | Relationship to Patient

_____ _____

Staff Member | Date