Authorization Form for Release of Protected Health Information to Individual(s) Named

Patient Name: _____ DOB: _____

I grant permission for my healthcare provider and their representatives of Lakeway Eye Physicians & Surgeons (LEPS), to discuss my care as per this disclosure form and to share relevant information about my **healthcare** specifically, **lab reports, diagnosis, treatment and medications**, or to discuss **financial** information for payment on my account with individual(s) designated below:

☐ **I do NOT want any of my information shared with family &/or friends**

Release my protected health information to the following person(s)/entity:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I understand that my healthcare information at Lakeway Eye Physician & Surgeons is protected. I have received this Notice of Privacy Practices and this document will be on record with LEPS.

Signature: _____ Date: _____

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Lakeway Eye Physician & Surgeons.