DIXIE OPHTHALMIC SPECIALISTS
at Zion Eye Institute

Chart #_____

Disclosure Authorization

Under the HIPAA privacy policy mandated by the federal government, unless we have written permission from you (the patient), our office will not be able to release medical or billing information to members of your family or any person who might contact us to obtain this information, even if this information is being obtained in your behalf. In order for Dixie Ophthalmic Specialists at Zion Eye Institute, to release this type of information without requiring a new form to be signed for each release of information, we are requesting that you list below any persons with whom we may share this information without further written consent from you. Any persons on this list will remain on your Disclosure Authorization until you remove them in writing. The list may include your spouse, son, daughter, relatives, care givers, or friends who act as an advocate in your health care or finances. Only the name of the person is required, but a phone number would be appreciated in order for us to help verify the identity of the person phoning. Thank you for your assistance with this matter.

I, _____ , consent to have information released to the following people. (Please Print)

Name of person who can obtain Medical or Billing Information This could be spouse, family, friend, care giver, etc.	Phone Number	Patient Initials