HIPAA DISCLOSURE FORM

Five Forks Family Eye Care* 117 Batesville Rd. Suite 201 Simpsonville, SC 29681

Dr. Trevor L. Klein O.D.

Patient Name: _____

Date: _____

Address: _____

Phone Number: _____

E-Mail: _____

Would you like our correspondence with you to be via mail, telephone, or email?

_____

May we identify ourselves over the phone? _____

May we leave a message? _____

I, the patient, hereby authorize the doctor listed above to release my medical information (appointments, diagnoses, treatments, etc.) via postal mail, telephone, or email to the following family members:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I further release my information to the following physicians, clinics, and/or hospitals:

Doctor: _____ Phone: _____

Doctor: _____ Phone: _____

Doctor: _____ Phone: _____