Permission to Communicate

Patient Name: _____

Patient DOB: _____ / _____/ _____

This form asks you to tell Coastal Eye Care who, besides you, is involved in your care, so that Coastal Eye Care may comfortably share information with them that is ***directly relevant*** to their involvement in your care or in payment for your care.

This form does *not* permit us to talk with anyone about substance abuse or mental health treatment, or about HIV/AIDS status or testing. To release that type of medical information about you to anyone, the law requires that we have a written authorization that specifically permits us to do that.

Some examples of the type of information we would anticipate sharing include:

- dates and times of your upcoming appointments
- your prescription refill information, dates or other medication information
- information about your test results
- the status of referrals or other care coordination issues
- financial information, including payments made and balances due

This form does not allow us to provide a copy of your medical records, nor does it allow others to make any medical decisions for you.

I give permission to the staff of Coastal Eye Care to disclose medical information to the following individuals listed below:

Name -Person to Receive Information / Relationship (e.g., spouse, friend etc.) / Phone Number

_____/_____/_____

_____/_____/_____

_____/_____/_____

This Permission to Communicate form will stay in effect unless revoked by you in writing.

_____ ___/___/_____

Patient Name (PLEASE PRINT) **Today's Date**

_____

Patient 's Signature (Parent's signature, if a minor)