

RELEASE FORM FOR PROTECTED HEALTH INFORMATION

I, \_\_\_\_\_, give *Coastal Eye Clinic, P.A.*, permission to speak to the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from *Coastal Eye Clinic, P.A.*

This consent is *valid* until such time as I provide *Coastal Eye Clinic, P.A.* written revocation of said consent.

*Coastal Eye Clinic* may speak with:

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_

RESTRICTIONS

May we call you at work:	Yes _____	No _____	N/A _____
Leave a message on your answering machine?	Yes _____	No _____	N/A _____
Send an appointment reminder?	Yes _____	No _____	N/A _____
Call on a cell phone?	Yes _____	No _____	N/A _____

Any other restrictions?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's signature \_\_\_\_\_ Date: \_\_\_\_\_  
Employee CEC: \_\_\_\_\_ Date: \_\_\_\_\_  
Restrictions accepted by *Coastal Eye Clinic*: Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_