Focused Eye Care

Release of Medical and Financial Information

Name: _____ DOB: _____

HIPAA privacy regulations require Focused Eye Care to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and financial information.

Please print first and last name and the relationship for each individual to whom you are authorizing release of the above information.

Name	Relationship
1.	
2.	
3.	

I understand I have the right to revoke this authorization in writing at any time and any information disclosed to the above individual(s) is no longer protected by federal or state law.

_____ _____

Patient Signature Date

David J. Helfman O.D.|F.A.A.O **Elliot F. Lasky** O.D. **Kelly M. MacDonald** O.D. **Scott D. Huffer** O.D.|F.A.A.O **Sarah E. Jagatic** O.D.
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