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 of Person to Receive Information **Relationship to Patient (e.g., spouse, child, friend)**

_____ /_____

_____ /_____

_____ /_____

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)