Central Eye Care, P.C.

Pediatric Ophthalmology and Strabismus

Authorization to Release Health Information

Commonly, medical care for a child requires the help of family members or friends. To make it simpler to discuss medical information about your child with people involved in his or her care, please complete this form.

☐ **I give permission to Central Eye Care, P.C. to release, as needed, my protected health information to:**

Person's Name: _____ *Relationship:*_____ *Phone #:* _____

Person's Name: _____ *Relationship:*_____ *Phone #:* _____

Person's Name: _____ *Relationship:*_____ *Phone #:* _____

Person's Name: _____ *Relationship:*_____ *Phone #:* _____

Person's Name: _____ *Relationship:*_____ *Phone #:* _____

☐ **I do not give permission to Central Eye Care, P.C. to release my protected health information to any family member or friend.**

Patient/Parent/Guardian's Signature: _____ *Date:* _____

Parent/Guardian's Printed Name (If Applicable): _____

Patient Name (PRINTED): _____ *Date of Birth:* _____

Central Eye Care, P.C. is committed to protecting patients' medical information. We will ask that the following question be answered before receiving records.

At which hospital was the patient born? _____