GRENE VISION GROUP

TOTAL EYE CARE FOR THE ENTIRE FAMILY

Authorization to Disclose Information to Those Involved in My Care

_______________________________ ____/____/____

Patient Name DOB

I hereby allow Grene Vision Group to disclose the following Protected Health Information:

- ❑ ALL Information (health & billing)
- ❑ All health information
- ❑ All Billing Information
- ❑ Appointment times and dates
- ❑ Other Disclosure Preferences: ____________________

To the following people because they are involved with my health care or payment:
(please print full name)

Name: ______________________ Relationship: ______________________
Phone number: ______________________ ❑ Ok to leave message

Name: ______________________ Relationship: ______________________
Phone number: ______________________ ❑ Ok to leave message

Name: ______________________ Relationship: ______________________
Phone number: ______________________ ❑ Ok to leave message

This authorization is effective through ___/___/___ unless revoked or terminated by the patient or patient's personal representative.

Signed: ____ Date: ________________
Patient (or Legal Representative and Relationship)

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