**Authorization for use or disclosure of health information (HIPPA)**

\*acknowledgement that I reviewed and understand Antioch Eye Associates HIPPA privacy policy.

By law, without authorization, Antioch Eye Associates cannot communicate with:

1. Your spouse
2. Your adult children or caregivers
3. Your parents (if over the age of 18)

Antioch Eye Associates may need to communicate with your family members or caregivers in the following circumstances:

1. Making appointments/ Confirming appointments
2. Picking up materials and prescriptions
3. Discussing treatments needed or preformed
4. Account, Financial or insurance information

**Please indicate below the names of people that Antioch Eye Associates can communicate with regarding your appointment, medical, or account information.**



 My Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 My Adult children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 My Parents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 My Caregiver \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I DO NOT wish to allow any of my information to be shared with anyone including my spouse, family member, or guardian.

**Emergency contact:** Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_

 (Please print) (Parent/guardian if under 18)