



CHICOPEE EYECARE, P.C.

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AUTHORIZATION TO RELEASE INFORMATION

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Act does not allow for unauthorized disclosure to a patient's family members, friends, or advisors. If the patient would like their protected health information released to someone other than himself or herself, they must complete this form. A patient cannot specify which information they would like to release to this third party. By completing this form, all protected health information may be released to the third party upon request until this agreement is terminated in writing.

I, _____, give Chicopee Eyecare P.C. permission to discuss with:

(Print Name) (Relationship to Patient) (Phone #)

(Print Name) (Relationship to Patient) (Phone #)

(Print Name) (Relationship to Patient) (Phone #)

(Print Name) (Relationship to Patient) (Phone #)

(Print Name)

Permission to leave a message on:

- home telephone answering machine
- work voice mail
- cell phone voice mail
- any information pertaining to my healthcare.

Signature: _____ Date: _____
_____ Print Full Name:
