CHICOPEE EYECARE, P.C.
113 Center Street · Chicopee, Massachusetts 01013 · (413) 592-7777
Katarzyna Babinski, O.D.
Brett P. Burns, O.D.
Camille Guzek-Latka, O.D.
David C. Momnie, O.D.

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)	(Relationship to Patient)	(Phone #)

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: _____