
113 Center Street ● Chicopee, Massachusetts 01013 ● (413) 592-7777

**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 else, 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 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 #)

Permission to leave a message pertaining to my healthcare on:

___ Home Phone #_____

___ Work Phone #_____

___ Cell Phone #_____

☐ Permission to send glasses or contact lens prescriptions via email, upon request

Signature: _____

Date: _____

Print Full Name: _____