Consent for Verbal Release of Information

Primary Phone Number: _____ Home Work Cell

Secondary Phone Number: _____ Home Work Cell

Leave Detailed Message? (please circle): Yes No

Please list any persons with whom we MAY share details about your health care. Indicate whether this may include private health information (PHI) such as exam results, billing questions or other health information.

Name Relationship

_____

_____

Release PHI? Yes No

I understand that this consent is valid until revoked by me and applies to information about me obtained through Watsonville Optometry. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the doctor. I also understand that I will not be able to revoke this consent in cases where the doctor has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the doctor's office.

Signature_____ Date: _____

Printed name: _____

Relationship to patient: _____

Authorization for Facsimile & E-Mail

Watsonville Optometry Fax and Email Request Authorization

I, _____ understand that you will be transmitting my medical records electronically and authorize you to do so. If another party received my medical records in error, I absolve Watsonville Optometry of any and all liability to such submission of said records.

Delivery Method

Please **FAX** my medical records to: (_____)_____

Please **EMAIL** my medical records to: _____

Patient's Name _____

Signature _____ Date: _____