PACIFIC RETINA CENTER

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care:

YOU MUST LIST THE NAME OF THE FAMILY MEMBER(S) OR PERSON(S) BELOW

_____

_____

Check all that may apply:

- o All my medical information
- o Information necessary to schedule appointments for me
- o Lab or test results
- o Information necessary to help my family member(s) take care of me
- o Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient of Pacific Retina Center, PLLC unless and until I notify Pacific Retina Center, PLLC in writing of any changes.

_____ _____

Signature of Patient or Representative Date

_____ _____

Patient's Name Patient's Date of Birth

_____

Relationship to Patient