Due to the **HIPAA Compliance Privacy Laws of the Federal Government**,
IT IS MANDATORY that we ask you to review and answer the following questions listed below.

Patient Name:_____________________________________ Date______/______/______

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ **Yes** □ **No** Home Phone:___________________________________
□ **Yes** □ **No** Cell Phone:_____________________________________

May we contact you at your place of employment? □ **Yes** □ **No**
If so, may we leave a message? □ **Yes** □ **No**

If yes: Work Phone: _________________________ Extension: _____________

Do you have any person(s) or family member(s) that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?
□ **Yes** □ **No** If yes, please provide:

Name:____Relationship:________________

Phone Number: ____________________________
Is this person your Power of Attorney for medical purposes? □ **Yes** □ **No**

Name:____Relationship:________________

Phone Number: ____________________________
Is this person your Power of Attorney for medical purposes? □ **Yes** □ **No**

I hereby authorize Eye Institute of Austin, to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked**.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Eye Institute of Austin's Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: __________________________________ Date______/______/______

WITNESSED BY:____