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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.

Name: _____

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: _____ Alternate Number:

Is this person your Power of Attorney for medical purposes? Yes
 No

Name: _____

Relationship:

Phone Number: _____

Alternate Number:

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: _____