LONGMEADOW EYECARE

HIPPA/COMMUNICATIONS AUTHORIZATION

PATIENT NAME_____DOB_____

Persons authorized to receive personal, billing and diagnostic info as well as test results:

- _____
- _____
- _____

I ALSO AUTHORIZE LONGMEADOW EYECARE TO:

- Leave messages on my home answering machine
- Leave messages on my cell phone
- Leave messages with the above mentioned

PURPOSE OF CONSENT: By signing this form, you give consent to disclose your protected health information in order to treat you, collect payment and to care for your health. You are responsible to update this consent form in the event of any changes. You also have the right to revoke this consent at any time with a written notice to Longmeadow Eyecare

PATIENT/ PARENT/ GUARDIAN

SIGNATURE_____ **DATE**_____