Talley Eye Institute

Authorization for Release of Identifying Health Information

From time to time we may have to call you on the phone or we may receive a call from your family or caregiver. In addition, groups such as nursing homes and transportation services will contact us to confirm appointment times. Please let us know your wishes with regards to whom we may speak with about your upcoming appointments, test results, billing question, or exam findings. You are allowing us permission to speak with the following individuals about your Protected Health Information (PHI):

Name	Relationship	We may discuss the following:
		☐ Your Appointment Date, Time, Location, and Doctor's Name ☐ Your Test Results ☐ Your Exam Findings ☐ Any Billing Questions ☐ Other _____
		☐ Your Appointment Date, Time, Location, and Doctor's Name ☐ Your Test Results ☐ Your Exam Findings ☐ Any Billing Questions ☐ Other _____
		☐ Your Appointment Date, Time, Location, and Doctor's Name ☐ Your Test Results ☐ Your Exam Findings ☐ Any Billing Questions ☐ Other _____

Please use the other side of this page to add more names if needed.

If you wish to add or remove individuals from this list, we ask that you let us know about this decision at your earliest convenience.

It is completely your decision whether or not to sign this form. We cannot refuse to treat you if you choose not to sign. If you sign now you may revoke it later by sending a written request to our office at Talley Eye Institute, 6149 E. Columbia St**, Evansville IN 4771**5.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described on this form.

Patient (or legal guardian) signature: _____Date: _____

Printed Name: _____

If you are the legal representative of the patient that you are signing for, describe your relationship to the patient and the source that gives you legal authority to sign this form:

Relationship to patient: _____ **Printed Name: _____**

Source of authority: _____ **Witness: _____**

Talley Eye Institute

Authorization for Release of Identifying Health Information (Continued)

Name	Relationship	We may discuss the following:
		☐ Your Appointment Date, Time, Location, and Doctor's Name ☐ Your Test Results ☐ Your Exam Findings ☐ Any Billing Questions ☐ Other ______________________________
		☐ Your Appointment Date, Time, Location, and Doctor's Name ☐ Your Test Results ☐ Your Exam Findings ☐ Any Billing Questions ☐ Other ______________________________
		☐ Your Appointment Date, Time, Location, and Doctor's Name ☐ Your Test Results ☐ Your Exam Findings ☐ Any Billing Questions ☐ Other ______________________________
		☐ Your Appointment Date, Time, Location, and Doctor's Name ☐ Your Test Results ☐ Your Exam Findings ☐ Any Billing Questions ☐ Other ______________________________
		☐ Your Appointment Date, Time, Location, and Doctor's Name ☐ Your Test Results ☐ Your Exam Findings ☐ Any Billing Questions ☐ Other ______________________________
		☐ Your Appointment Date, Time, Location, and Doctor's Name ☐ Your Test Results ☐ Your Exam Findings ☐ Any Billing Questions ☐ Other ______________________________

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described on this form.

Patient (or legal guardian) signature: ______________________________________**Date:** ___________________

Printed Name: ____