HIPAA 1 226 Authorization to Release Protected Health Information
To Friends or Family Members

*Please complete this form **only** if you wish to give us permission to speak directly with a friend or family member about your appointments, care plan, or any other protected health information related matter.*

Name of Patient: _____

Date of Birth: _____ Account Number: _____

I hereby authorize medical providers and personnel of Spokane Eye Clinic and Spokane Eye Surgery Center to discuss my protected health information with:

(Printed Name)	(Phone #, with area code)	(Relationship)
(Printed Name)	(Phone #, with area code)	(Relationship)
(Printed Name)	(Phone #, with area code)	(Relationship)

I understand certain protected health information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information (check all that apply).

_____ Information regarding a diagnosis and treatment for HIV/AIDS

_____ Information specific to mental health or illness _____Information specific to drug and/or alcohol abuse

_____ Information specific to a sexually transmitted disease and/or reproductive care

***Minors** – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).*

_____
(Minor patient's Signature)

This authorization shall remain in effect for all past, present, and future periods unless revoked, preferably in writing, at any time by notifying your eye doctor or his/her staff.

- I understand I have the right to revoke this authorization, in writing, at any time.
- I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand I have the right to refuse to sign this authorization.

Signature of Patient/Personal Representative **Name of Patient/Personal Representative**

Date and Description of Personal Representative's Authority **Phone number, including area code**