



Thomas Eye Group, P.C.

Authorization To Release Protected Health Information (PHI) and Obtain and Use Prescription History

1. With your permission, we may disclose your PHI to the individuals identified below. I authorize Thomas Eye Group, PC to release any personal information relating to my health care.

To: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_

To: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_

2. I understand that I have the right to restrict information that may be released and that this restriction must be in writing.

\_\_\_\_\_ No restrictions

\_\_\_\_\_ With restrictions (list): \_\_\_\_\_

3. I agree that Thomas Eye Group, PC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

4. I have received a copy of the Notice of Privacy Practices for Thomas Eye Group, PC and I acknowledge that I am familiar with and understand the terms and conditions.

\_\_\_\_\_ Name \_\_\_\_\_ Date

\_\_\_\_\_ Signature

AUTHORITY FOR TREATMENT

IF PATIENT IS A MINOR, FILL IN THE FOLLOWING INFORMATION

No child under the age of 16 (sixteen) may be left unattended!

I hereby authorize the providers at Thomas Eye Group to examine, diagnose and treat the person listed below, for whom I am legally authorized to give consent. I authorize such services that the provider feels are necessary or advisable and are rendered under the provider's general or specific instructions.

Form with fields for Patient Name, Date of Birth, Parent/Legal Guardian Signature, Occupation, Name, Relationship, Date, Divorced status, and Guardian appointment.