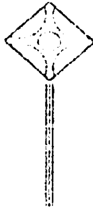

EYE HEALTH PHYSICIANS OF LANCASTER

SANDFORD C. FRISCH, M.D.
Diplomate American Board of Ophthalmology
Specializing in Glaucoma Management

DIANE B. CATANIA, O.D.
Doctor of Optometry
Providing Comprehensive Vision Care

Authorization To Receive/Release Health Information

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 particular person or family members 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 Health Physicians of Lancaster 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.

A copy of Eye Health Physicians of Lancaster's HIPAA Privacy Policy is on file. A copy of this policy will be provided to me upon request.

Patient Signature: ______________________ Date: ______________________