CONSULTING OPHTHALMOLOGISTS, P.C.
499 Farmington Avenue, Suite 100 704 Hebron Avenue, Suite 200
Farmington, Connecticut 06032 Glastonbury, Connecticut 06033
Office Phone: (860) 678-0202 (860) 368-2235
www.consultingeye.com

Authorization to Share Information

Name: _____ Date of Birth: _____

With whom do you allow us to share your personal information?

Name _____Relationship: _____ Phone:_____

Name _____Relationship: _____ Phone:_____

Name _____Relationship: _____ Phone:_____

_____ I authorize you to share my **appointment and demographic information** with the above individuals at my request.

_____I authorize disclosure of **personal medical information** with the above individuals (this includes information such as diagnosis, records, examination rendered, claims information and portal information) at my request.

Expiration Date:

[ ] This agreement will remain in effect until terminated by me in writing without exception.

[ ] _____ Specified Date of termination

I understand I can revoke this authorization at any time by providing written authorization to Consulting Ophthalmologists.. I understand failure to authorize does not restrict from exceptions detailed in the Notice of Privacy Practices or HIPAA.

_____

Signature Date

If the signing individual is not the individual that this agreement represents, please identify your authorization to represent (ex. power of attorney).