CONSULTING OPHTHALMOLOGISTS, P.C.

499 Farmington Avenue, Suite 100 **295 Western Boulevard**
Farmington, Connecticut 06032 **Glastonbury, Connecticut 06033**
Phone: (860) 678-0202
www.consultingeye.com

Authorization to Share Information

Patient Name: _____ Patient Date of Birth:

☐ **I do not wish to share my information with anyone at this time.**

_____ _____

Signature **Date**

☐ **I do wish to share my information with the following:**

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

Name: _____ Relationship: _____ Phone:

Name: _____ Relationship: _____ Phone:

Name: _____ Relationship: _____ Phone:

Please complete the following statements:

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

☐ **Y** ☐ **N** 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.

☐ **Y** ☐ **N** I authorize the sharing of all **billing Information**

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

_____ _____

Signature Date

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

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.

Revised 11-14-2022