CONSENT FOR RELEASE OF
PROTECTED HEALTH INFORMATION TO FAMILY

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care:

YOU MUST LIST THE NAME OF THE FAMILY MEMBER(S) OR PERSON(S) BELOW

_____

_____

Check all that may apply:

- o All my medical information
- o Information necessary to schedule appointments for me
- o Lab or test results
- o Information necessary to help my family member(s) take care of me
- o Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient of Piedmont Retina Specialists, PA unless and until I notify Piedmont Retina Specialists, PA in writing of any changes.

_____ _____

Signature of Patient or Representative Date

_____ _____

Patient's Name Patient's Date of Birth

_____

Relationship to Patient

Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S. § 8-53, and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.

PATIENT ACKNOWLEDGMENT AND CONSENT

I have been given a copy of Piedmont Retina Specialists, PA's Notice of Privacy Practices and Financial Responsibility. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative Date

_____ _____

Print Name Patient's Date of Birth

_____

Relationship of Representative to Patient

Please Initial Below:

I understand I will be charged $15.00 for a full printed record. _____

I understand that any FMLA, DMV or other Forms will be charged a fee

of $20.00 per form for completion. _____

May we call you at: (Circle one)

Home - Yes or No Work – Yes or No Cell – Yes or No

May we leave a message? Yes or No