ROSIN EYECARE

When the Decision is Vision

Consent for Verbal Release of Information

Type (please circle) Leave Detailed Message

Primary Phone Number: _____ Home Work Cell Yes No

Secondary Phone Number: _____ Home Work Cell Yes No

Please list any persons with whom we MAY share details about your health care. Indicate whether this may include private health information (PHI) such as exam results, billing questions or other health information.

Name	Relationship	Release PHI?
_____		Yes No
_____		Yes No

I understand that this consent is valid until revoked by me and applies to information about me obtained through any and all Rosin Eyecare locations and doctors. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the doctor. I also understand that I will not be able to revoke this consent in cases where the doctor has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the doctor's office.

Signature_____ Date: _____

Printed name: _____

Relationship to patient: _____

Authorization for Facsimile & E-Mail

Rosin Eyecare and Comprehensive Eyecare Physicians Fax and Email Request Authorization

I, _____ understand that you will be transmitting my medical records electronically and authorize you to do so. If another party received my medical records in error, I absolve Rosin Eyecare & Comprehensive Eyecare Physicians of any and all liability to such submission of said records.

Delivery Method

Please **FAX** my medical records to: (_____)_____

Please **EMAIL** my medical records to: (_____)_____

Patient's Name _____ Signature _____

Date: _____