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Connecticut Eye Physicians and Surgeons, LLC
479 Buckland Rd, South Windsor, CT 06074

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: _____ DOB: _____

May we leave messages/detailed medical information at either of these phone numbers?

Home: (_____)_____ □ Yes □ No Cell Phone: (_____)_____ □ Yes □ No

May we contact you by email? □ Yes (email: _____) □ No

May we contact you at your place of employment? □ Yes □ No

If yes, Work Phone: _____ ext. _____

Do you have any particular person or family member that you authorize to receive and discuss information regarding your personal health information (general, medical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: (_____)_____ Alternate phone number: (_____)_____

Does this person have medical Power of Attorney for you? □ Yes □ No

If Power of Attorney for medical purposes is held by a different person, please provide the information:

Name: _____ Relationship: _____

Phone Number: (_____)_____ Alternate phone number: (_____)_____

I hereby authorize Connecticut Eye Physicians and Surgeons to obtain or release any and all pertinent information regarding my medical care, as needed, to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the CEPS Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

(If signed by other) Name: _____ Relationship: _____