RETINA SPECIALISTS of Idaho, PLLC

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PROTECTED HEALTH INFORMATION RELEASE: PATIENTS 18 YEARS AND OLDER

Patient Name: _____ DOB: _____

☐ Only release information to me personally

☐ You have my permission to speak with my spouse/significant other about my medical care and test results.

Spouse/significant other's name: _____ Phone: _____

☐ You have my permission to talk with my children or other family members involved with medical care.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

☐ You have my permission to leave information on my answering machine regarding my medical care and test results.

☐ Other (please describe):_____

Emergency contact:

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell: _____ Other phone: _____ ☐ hm ☐ wk

Relationship:_____