

**CONSENT TO DISCLOSE PATIENT HEALTH INFORMATION
TO FAMILY AND FRIENDS INVOLVED IN PATIENT CARE**

Patient Name: _____ Chart: _____

I understand that LaHaye Total Eye Care will not disclose my protected health information to my family, relatives, or friends, except in emergency situations.

I understand that LaHaye Total Eye Care may disclose my protected health information to a family member, relative, friend or other person that I identify who is directly involved in my care, or payment of my care, provided that I have an opportunity to agree to, or object to, such disclosure.

The individual(s) identified below is or are directly involved in my care and I would like such individual(s) to give information to, and receive information from, LaHaye Total Eye Care regarding my medical condition and treatment. Therefore, I hereby consent, agree, and authorize LaHaye Total Eye Care to disclose my protected health information to the following individual(s) who is or are directly involved in my care, or in the payment of my care:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I understand that by consenting to the disclosure of my protected health information to the individual(s) identified above, **all** my personal information relevant to my care and treatment may be disclosed, including but not limited to, my medical history, my medical condition, diagnostic tests performed, laboratory results, surgical procedures, and other personal information given to, or discussed with, LaHaye Total Eye Care.

This consent to disclose my protected health information applies to [check the appropriate box]:

- This visit only
- All visits at which the individual(s) identified is or are present
- All communications with the individual(s) identified above, including information provided in person, by telephone, or by mail.

This consent is immediately effective and shall remain effective until I revoke it. I understand that I have the right to revoke this consent at any time by providing written notice to LaHaye Total Eye Care. I understand that I am not required to sign this form in order to receive treatment, and that I am voluntarily requesting and consenting to LaHaye Total Eye Care's disclosure of my protected health information to the individuals identified above.

Patient Signature _____ Date _____