# Authorization for Disclosure of PHI to Family/Friends

**This form is optional**. Please print information if you would like to include someone in your care. Sign and Date at bottom.

Patient Name: _____

SEME Account #: _____ Date of Birth: _____

Entity Requested to Release Information: _____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

Who will be authorized to receive information (the individual/entity whom is to receive your PHI):

_____
Name of Person Authorized & Date of Birth Relationship

_____
Name of Person Authorized & Date of Birth Relationship

_____
Name of Person Authorized & Date of Birth Relationship

* **Secure Communication** - Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

Entire patient record; **or**, check **only** those items of the record to be disclosed:

□ **All Medical Records**

□ Lab results, pathology reports □ Eyeglass Prescriptions

□ Visual Testing □ Contact Lens Prescriptions

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

□ Patient Request □ other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
Patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.