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
______________________________	______________________________	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: ______________________________