REQUEST FOR PERMISSION OF PROTECTED HEALTH INFORMATION

DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

SIGNATURE (OR GUARDIAN): _____

RELATIONSHIP TO PATIENT: _____

I hereby authorize the following individuals to interact with employees of **Eye Physicians of Central Florida** to receive and provide PHI regarding me. This listing shall remain in effect until revoked in writing by me.

NAME	RELATIONSHIP TO PATIENT

RESTRICTIONS ON USE/DISCLOSURE OF PHI:

_____

_____

_____