Davis Eye Clinic

HIPAA PATIENT CONFIDENTIALITY RELEASE FORM

Who can we speak with about your medical care?

____You can only speak with me

____You can speak with me or any of the following:

Name_____Relationship_____
Name_____Relationship_____
Name_____Relationship_____
Name_____Relationship_____

Patient Printed Name_____Date of Birth_____

Patient Signature_____Date_____

I understand this authorization will remain in effect until changed or rescinded by me.