Patient Disclosure and Emergency Contact Form

I authorize Eyecare Center of Leesburg to disclose information on my behalf to the person(s) below (Name and Phone Number):

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In the event of an emergency, please contact the person(s) listed below (Name, Phone Number & Relation):

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I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization.

The information on this form will remain in effect until otherwise stated verbally and or in writing.

Patient (print): ______________________________ Date: ___________________

Signature: ____