MACHA FAMILY EYE CARE, PC

1537 S. Scatterfield Rd.   Anderson, IN   46016

Phone: 765-649-1200 | Fax: 765-649-4040

HIPAA Release Form

Name: ______________________________ Date of Birth:__/___/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name: ______________________________________ Relationship:____________________________

Name: ______________________________________ Relationship:____________________________

- o Information may not be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell phone Number:_____________

If unable to reach me:

- o You may leave a detailed message
- o Please leave a message asking me to return your call
- o Other ___________________________________

The best time to reach me is ____________________________________

Signature:____ Date:__________________________

Witness:____Date:__________________________