MILWAUKEE EYE CARE

Patient Communication Form
Family & Friends

It is the office policy of Milwaukee Eye Care Associates not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume that, unless you object, that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate their name and relationship. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse / Partner: _____

Parent(s): _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ I do not anticipate any family members or friends to inquire on my behalf.

Patient Printed Name: _____

Patient / Parent / Guardian Signature: _____

Date: _____

FOR OFFICE USE

Changes to the above authorization by patient over phone:

Change	Date	Staff Initials