AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH

INFORMATION TO INDIVIDUALS

Name of Patient: _____ Date of Birth: _____

I understand that EYE PHYSICIANS OF ST. LOUIS (EPSL) DBA STL Vision, from time-to-time, may be requested to disclose my protected health information (PHI) with members of my family or a close friend. *Without express written permission from me, EPSL will not disclose or discuss my information with anyone other than me*. Therefore, I authorize EPSL to disclose my PHI for the following purposes:

- □ Obtain test or lab results on my behalf
- □ Discuss my current health condition or symptoms
- □ Pick-up written prescriptions or pharmaceutical samples on my behalf
- □ Other:
- □ All the above

with the following individuals:

Person's Name	**Relationship to Patient**	**Phone Number**

I understand that if information is requested via telephone, the caller will be asked to identify me by providing (a)my name and my date of birth as shown on EPSL's records, and (b) the caller's full name shown above. If the request is made in person, the individual will be required to provide proper identification, including a picture ID.

I understand that in order to add or delete designated people from this list, I must notify EPSL in writing. I also understand that I may revoke this authorization in its entirety by providing written notification to EPSL, or signing a Revocation of Authorization for Disclosure of Health Information form provided by EPSL.

I understand that this authorization excludes EPSL from providing copies of my medical records to the above individuals without the proper release form.

Signature of Patient or Personal Representative_____
Date: _____