Designation of Care Givers for Communication of Protected Health Information

For the following patient: Current Date: ____/____/____

Patient Name:_____ Date of Birth: ____/____/____

At my request, I authorize the person(s) listed below to inquire about my personal health and/or billing information on my behalf. In case of a minor child, this Person(s) may inquire about the child's personal health and/or billing information and, if necessary, bring the child to apppointments on my behalf.

Name	Relationships	Date of Birth	Phone number(s)
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OR

_____(init) **I do not** want any of my personal or financial information to be given to anyone other than myself and my physicians.

At my request, I authorize Carolinas Centers for Sight, P.C. to communicate my protected health information to me via the following methods:

_____ Leave detailed message on my home answering machine.(Phone #_____

_____ Leave message with call-back number only.

_____ Leave detailed message on my voice mail at work.(Phone#_____

_____ Leave detailed message on my cell phone voice mail.(Phone#_____

_____ E-mail detailed medical information.(e-mail:_____

_____ OK to mail to my home address.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Rights of the patient: I understand that I have the right to revoke this authorization at anytim by sending a written notification to Carolinas Centers for Sight, P.C.

_____Date:_____
Signature of Patient or Personal Representative

_____
Print name of Patient or Personal Representative

_____
Personal Representative Authority(attach necessary documentation)