Disclosure to Relatives, Close Friends, and Other Caregivers

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to the following:

St. Lucy’s Eye Care Center and its authorized representatives may use or disclose personal health information (“PHI”) to a family member, other relatives, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to the disclosure. ***If I object to such uses or disclosures, I will notify the Office Manager.***

If I am not present, am incapacitated, or am in an emergency circumstance, St Lucy’s Eye Care Center may exercise its professional judgment to determine whether a disclosure is in my best interest. If St. Lucy’s Eye Care Center discloses information to a family member, other relative or a close personal friend, it would disclose only information that is directly relevant to the person’s involvement in my health care or payment related to my health care. St Lucy’s Eye Care Center may also disclose PHI in order to notify (or assist in notifying) such persons of my location, general condition or death.

Signature Date

Please identify the person(s) that we can speak with in regards to your medical information:

Name Phone # Relationship

Name Phone # Relationship

Name Phone # Relationship

**Emergency Contact**

If different from above please specify below:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_