INDIANA VISION
Development Center, PC

Effective date of Notice: January 1, 2019

Carl O. Myers, O.D., FCOVD
Indiana Vision Development Center
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Authorization to Discuss Your Information with Family or Caregivers

To comply with the new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including your spouse, children, family members, caregivers, friends, etc. By authorizing this, we will be able to, without your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person (s) listed below. **If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below.** This authorization is optional and can be withdrawn at any time.

Name _____ Name _____

Relationship _____ Relationship _____

Phone _____ Phone _____

Name _____ Name _____

Relationship _____ Relationship _____

Phone _____ Phone _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received _____ or declined_____ a copy of Dr. Carl O. Myers notice of Privacy Practices as required by Federal Law. I further authorize the above-named individuals to receive information concerning my child's / my records.

_____
Patient's Full Name (printed)

_____
Parent or Guardian Name (printed)

_____ _____ _____
Patient/Parent or Guardian Name (signature) Date Staff Initial