# Warrior Eye Care

**Patient Name: _____**
**Date of Birth:_____**

Dr. Faye Andrews, OD, staff, employee or representative of Warrior Eye Care has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medication or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

| _____ | _____ | _____ |
|---|---|---|
| **Name** | **Relationship** | **Phone Number(s)** |
| _____ | _____ | _____ |
| **Name** | **Relationship** | **Phone Number(s)** |
| _____ | _____ | _____ |
| **Name** | **Relationship** | **Phone Number(s)** |

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Warrior Eye Care or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject the redisclosure by the individual(s).

**Patient Signature_____Date_____**

*********PLEASE FLIP OVER AND SIGN REVERSE SIDE************