



SIERRA
EYE CARE

Patient Authorization Regarding Protected Health Information

I, _____ give Sierra Eye Care and Sierra Eye Wear the permission to discuss or release my Protected Health Information (PHI) to the person(s) listed below.

Please check all that apply and *write the name* of the person(s) you are granting permission.

- My spouse
Name: _____
- My son(s) and/or daughter(s)
Name(s): _____
- My brother(s) and/or sister(s)
Name(s): _____
- My caretaker(s)
Name(s): _____
- Other(s)
Name(s): _____
- NONE

Signature

Date