I, ____________________________, give Innovative Eye Care permission to speak with the following people regarding my personal health information. This includes permission pertaining to diagnosis, treatment options and plans. It also includes permission to discuss payment for health services received from Innovative Eye Care. I understand that sharing health information with specialists and other health providers is necessary and not excluded by this form. This form give Innovative Eye Care permission to share health information with nonprofessionals such as extended family members should I so desire.

This consent is valid until such time as I provide Innovative Eye Care written revocation or it.

Patient Name:____

Patient DOB:____

Innovative Eye Care may speak with:

1) **Name:**____

   Relationship:____

2) **Name:**____

   Relationship:____

3) **Name:**____

   Relationship:____

Patient/Guardian Signature:____________________________________

Date:___________________

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