EYE CARE CENTER OF LAKE COUNTY, LTD.
310 S. GREENLEAF STREET, SUITE 209
GURNEE, IL 60031-5708

Patient name: ____ **Date of birth**: ____________________

PATIENT COMMUNICATION FORM (HIPAA)

It is the office policy of Eye Care Center of Lake County, Ltd. not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other person authorized by patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless your object, that person is entitled to receive information regarding your treatment),(iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on or delete names, please confirm this in writing.

□ Spouse (name): ____ Phone: __________________________

□ Mother (name): ____ Phone: __________________________

□ Father (name): ____ Phone: __________________________

□ Adult Child (name): ____ Phone: __________________________

□ Adult Child (name): ____ Phone: __________________________

□ Adult Child (name): ____ Phone: __________________________

□ Other: ____ Phone: __________________________

□ School: ____ Phone: __________________________

□ Employer: ____ Phone: __________________________

Name of contact/person: ___________________________________

____ ________________________________
Patient's signature (if minor under the age of 18 then parent/legal guardian) Date signed

____ ________________________________
Print name of person signing form Relationship to patient if not self

Form updated 5/8/19