Treasure Valley Eyecare

HIPPA RELEASE OF INFORMATION

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Patient Name (Print Please)

______/______/______

DOB

It is our policy to keep all matters regarding our patients in strict confidence. Please provide us with the names of your relatives and/or friends who may call for information about your appointment times, test results or any other pertinent medical information.

Name	Relationship
____	____
____	____
____	____
____	____
____	____

Is it okay for the staff at Treasure Valley Eyecare to leave a detailed message?

______YES ______NO

____ _____/_____/_____

Patient or Guardian Signature **Date**

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RELATIONSHIP

1702 S Kimball Avenue · Caldwell, Idaho 83605 · (208) 459-2641 · Fax 208-459-2895