ERIK S. BARRETT, M.D.
BARRETT EYE CARE
11450 N. Meridian Street
Suite 120
Carmel, Indiana 46032
Office Phone: 317-872-8772

MEDICAL RECORD INFORMATION IS NEVER RELEASED WITHOUT YOUR PERMISSION

I have read the NOTICE OF PRIVACY PRACTICES from the office of Erik S. Barrett, M.D. and wish to authorize one of the following - Section 1) OR 2a,b):

1) INFORMATION WILL ONLY BE RELEASED TO MY HEALTH CARE PRACTIONERS FOR CONTIUINTY OF CARE. ANY OTHER RELEASE WILL REQUIRE A SIGNED RELEASE OF MEDICAL RECORDS WITH ORIGINAL SIGNATURE. I understand this office will continue to safeguard my information as is their practice. I understand this authorization is voluntary and I may revoke this policy, in writing, at any time.

INITIAL: X _____

OR:

2a) HAVE YOU APPOINTED A HEALTH CARE REPRESENTATIVE (HCR)? A HCR is someone you have legally appointed to make health care decisions for you. If you have not appointed a HCR, please skip to 2b.

_____ Yes _____ No

IF Yes, fill in name(s) of your HCR(s)

Name(s) of your HCR(s) _____ Date _____
_____ Date _____

I give my consent and authorization for this person or persons I list above to act as my HCR to receive any and all information from my medical records, or discuss any and all aspects of my medical care. I also understand that I may revoke this privilege at any time by submitting my request, in writing, to this office.

2b) RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICE MAIL. I give my consent and authorization for the medical or billing staff of my Physician's office to leave Protected Health Care information (PHI) about me or for me on my answering machine or voice mail via the telephone at the number I have listed below. I also understand that I may revoke this privilege at any time by submitting my request, in writing, to this office.

TELEPHONE NUMBER: _____ INITIAL: _____

Signature of patient/representative: X _____Date: _____

Signature of witness: _____ Date: _____

**********YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**********

(Why patient refused to sign: _____

Witness: _____ Date: _____)