

Race

<input type="checkbox"/> African American	<input type="checkbox"/> Arab	<input type="checkbox"/> Asian	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Unknown
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Indian	<input type="checkbox"/> Multiracial	<input type="checkbox"/> Other Race	<input type="checkbox"/> Declined to supply	

Ethnicity

Hispanic or Latino Not Hispanic or Latino Declined to supply

Preferred Language

English Spanish Other _____ Declined to supply

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Lens Doctors to release my records and any information including billing information to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____
5. _____ Relation to Patient: _____

Patient Name (PLEASE PRINT)

Patient Signature or Guardian (if minor) _____
Date

We will continue to rely on the information on this form unless you request changes. It is your responsibility to immediately notify us of a divorce, legal separation, change in custody arrangement, or any other circumstance, which may alter this authorization.

To revoke or alter this authorization, please send a written request with a copy of this form to the address below:

Lens Doctors
605 Lafayette Rd.
Portsmouth, NH 03801