Designated Party Release

Ross Eyecare Group, P.C.

You may give **Ross Eyecare Group, P.C.** written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (glasses and/or contact lens status, claims information, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, e-mail, or another party that you designate.

Patient's Name	Date of Birth

At my request, I authorize **Ross Eyecare Group, P.C.** to disclose my protected health information to:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

At my request, I also authorize **Ross Eyecare Group, P.C.** to communicate my protected health information to me via the following methods:

☐Leave detailed message on my home answering machine. Phone number: (___) ___-____

☐Leave detailed message on my voice mail at work. Phone number: (___) ___-____

☐Leave detailed message on my cell phone voice mail. Phone number: (___) ___-____

☐Fax detailed medical information. FAX number: (___) ___-____

☐E-mail detailed medical information. Email address_____

☐I agree to receive text messages to this mobile phone number (___) ___-____ reminding me about my upcoming appointments. I understand that SMS reminders are optional and that message & data rates may apply.

I understand that I may cancel this authorization at any time. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action **Ross Eyecare Group, P.C.** took in reliance on this authorization before receipt of written notice of cancellation.

I understand that electronic media, and delivery methods such as email, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of **Ross Eyecare Group, P.C.** I agree to assume such risks personally, and to hold **Ross Eyecare Group, P.C.** harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing **Ross Eyecare Group, P.C.** to transmit or deliver such information electronically.

Patient's Name	Date of Birth