Howerton Eye Clinic, PLLC – Medical Authorization Form

## AUTHORIZATION FOR MEDICAL INFORMATION

- I authorize my medical information, diagnosis, and treatment to be discussed with:

Name: ______________________ Phone: ______________________ Relationship: ______________

Name: ______________________ Phone: ______________________ Relationship: ______________

Name: ______________________ Phone: ______________________ Relationship: ______________

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_____________________________________________________________________________

Signature of Patient/Representative Date

_____________________________________________________________________________

Print Name of Patient /Representative Relationship to Patient

## NOTICE OF PRIVACY PRACTICES

- I have received a copy of Howerton Eye Clinic's Notice of Privacy Practices for review.

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Signature of Patient/Representative Date

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Print Name of Patient /Representative Relationship to Patient