GLAUCOMA
CENTER OF
SAN FRANCISCO

55 Stevenson Street
San Francisco, CA 94105
Tel: (415) 981-2020
Fax: (415) 981-2019
frontdesk@glaucomasf.com
www.glaucomasf.com

Andrew G. Iwach, M.D.
Shan C. Lin, M.D.
Terri Pickering, M.D.
Sunita Radhakrishnan, M.D.
Sophia Hsiao, O.D.

Emeritus
H. Dunbar Hoskins, Jr., M.D.
Robert N. Shaffer, M.D., *1912-2007*
John Hetherington, Jr., M.D., *1930-2020*

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

Name: ____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: ________________________

□ Yes □ No Cell Phone: __________________________

May we contact you at your place of employment? □ Yes □ No

If so, may we leave a message? □ Yes □ No

If yes: Work Phone: ____________________ Extension: ___________

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□ Yes □ No If yes, please provide:

Name: ______________________________ Relationship: ______________________

Phone Number: ________________________ Alternate Number: __________________

Is this person your Power of Attorney for medical purposes? □ Yes □ No

If no, please provide your Power of Attorney for medical purposes if applicable:

Name: ______________________________ Relationship: ______________________

Phone Number: ________________________ Alternate Number: __________________

I hereby authorize _______________________________ to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed the Notice of HIPAA Privacy Policy provided and consent to use and disclosure of protected health information about myself for treatment, payment, and health care operations. A copy of this policy will be provided to me upon request.

Patient Signature: ________________________________ Date: _________________

WITNESSED BY: _________________________________