INSIGHT VISION GROUP

Authorization to Verbally Discuss Protected Health Information

**Note: This form is optional. In order for this form to be valid, all information must be completely filled out.*

Patient Name:_____ Date of Birth:_____

I hereby give permission for InSight Vision Group and affiliates to verbally discuss the following medical and billing information about me (check all that apply):

☐ Scheduling/appointment information

☐ Medical information, including my symptoms, diagnosis, medications and treatment plan.

☐ Lab/Test results

☐ Billing and payment information

☐ All information

☐
Other:_____

InSight Vision Group and affiliates has my permission to discuss the above information with:

Name	Phone Number	Relationship to Patient

I understand that I may cancel this permission at any time by notifying InSight Vision Group in writing; however canceling permission will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

_____ _____

Signature of Patient or Parent/Legal Guardian *Date*