25022 104th Ave SE, Suite D
Kent, WA 98030
(253) 859-1911

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMEBERS

Many of our patients allow family members such as their spouse, parents, or others to call and request information regarding account, medical and billing information. Under the requirement of HIPAA, we are not allowed to give this information to anyone without the patient's prior consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below.

You have the right to revoke this consent in writing. I allow Benson Vision Source to release my medical and/or billing information to the following individual(s):

_____ Relationship to Patient _____

_____ Relationship to Patient _____

_____ Relationship to Patient _____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE:

Sometimes it is necessary for our staff to leave messages for patients. The purposes of these messages are to remind patients of scheduled appointment times, notifications of glasses and/or contact lenses being ready for pickup, discuss test results, or to speak with the patient regarding an issue or concern. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing. I allow Benson Vision Source to leave a message with a household member or on my voicemail.

Print Patient Name: _____

Signature: _____Date: _____
(if patient is under 18 Parent/Guardian must sign instead)