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Cascade EyeCare Center

Douglas R. Merritt, M.D.
Rodney D. Leavitt, M.D.
Matthew R. Guymon, D.O.
Matthew D. Fullmer, D.O.

Physicians & Surgeons • Ophthalmology

PERMISSION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ Date _____ Pt. ID# _____
(please print) *(for office use only)*

We may disclose your health information to a family member, personal representative, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Please list the individuals below who have your permission to share your health information. Cascade EyeCare Center, PC will request their date of birth as a form of identification.

Name	Relationship to Patient	Date of Birth (For ID)	Phone	Please check if this is also your emergency contact
				☐
				☐
				☐
				☐
				☐

My signature below authorizes Drs. Douglas R. Merritt, Rodney D. Leavitt, Matthew R. Guymon, and Matthew D. Fullmer dba Cascade EyeCare Center, PC to disclose my medical and/or billing information to the above listed persons.

Signed _____ Date _____

Patient e-mail address _____