KOKOPELLI EYE INSTITUTE

OUR VISION IS TO CARE ABOUT YOURS

Authorization to Share Patient Information

Please list anyone with whom you might need Kokopelli Eye Institute to share information. This would include any information that might be conveyed to any other person in your family or a caretaker. Information you are authorizing us to share to include medical records, including patient histories, test results, referrals, consults, appointment dates and times, billing records, insurance records, and records received from other health care providers.

Should this information change, please let us know in writing.

Please list the person or persons we have permission to share your information with:

1. _____
2. _____
3. _____
4. _____
5. _____

Patients Name (Please Print) _____ DOB _____

Patient Signature _____ Date _____