CENTRAL KENTUCKY EYECARE
FAMILY SHARED RELEASE

PATIENT INFORMATION – SECTION 1

Name_____ **DOB**_____

-If a minor patient, BOTH parents will have access to health and ledger information unless court ordered restriction. Paperwork is required-

****As a parent/guardian, I understand that this shared release is no longer valid when the individual(s) turn 18 years of age****

SECTION 2

A. **_____I DO NOT give permission for anyone to have access to any information.**

IF you want additional family members or friends to have access to your medical information or a minor's medical information, please check mark 'B' and fill out below.

B. ____I give my permission for the following information to be shared with the following individuals below. I understand this release is valid for 2 years from today's date. I can SHORTEN the length of this release, but I cannot extend it. ***(MUST FILL OUT SECTION II)***

C. ____I give RESTRICTED access to my medical records – specify time frame if less than a year.
Expiration date:_____

***Patient/Parent/Guardian Signature:_____**

Section 3 – *MUST be filled out if B or C chosen in Section 2*

A. Information to be shared. Please check all that apply.
   a. ____Medical Records Only
   b. ____Billing/Ledger Information Only
   c. ____ALL of the above

B. Who can have access to the above information – ***NAME AND RELATIONSHIP***
   a. _____

   b._____

   c._____