

**HIPAA Statement:**

 **I authorize, Silk Vision and Surgical Center to furnish to my insurance company or authorizing agency, information regarding my protected health information, for the purposes of treatment, payments or healthcare operations. I further authorize the physician(s) of Silk Vision and Surgical Center to consult as needed in their sole discretion with other medical providers regarding my medical care. I wish to place the following restrictions concerning the disclosure of my protected health information:**

**Silk Vision and Surgical Center, may discuss my medical information/ condition with the following**

**People:**

**1: 2: 3:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Signature of Authorized Person Date**