FRANK EYE CENTER

DR. KENNETH J. FRANK, M.D. DR. CHAD S. MIES, O.D.

HIPPA FORM 2026

Patient Name: _____ DOB: _____

This form allows you to give Frank Eye Center permission to discuss your Protected Health Information with a person(s) you appoint as your Personal Representative.

You are not required to name a Personal Representative, but if you do not, we will not disclose your Protected Health Information to someone who may call on your behalf. Your Personal Representative may be anyone of your choosing such as a spouse, parent, child or friend. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

You may revoke this designation of a Personal Representative at any time by giving written notice to the Privacy Official. (Please check one below)

- I decline to name a Personal Representative. Please check box, sign and date this form. ***
- Restricted Access. All requests approved by patient only. ***

1.) Personal Representative

Full Name: _____ Relationship: _____

Contact Phone: _____

Any limitations on issues your personal representative may discuss: YES NO If yes, please specify (example: Medical, financial, etc.):

2.) Personal Representative

Full Name: _____ Relationship_____

Contact Phone: _____

Any limitations on issues your personal representative may discuss: YES NO If yes, please specify (example: Medical, financial, etc.):

- This authorization will expire three years from date of signature, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: ____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your PHI. Therefore, your PHI disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____

Patient or authorized representative signature date