Dr. Craig A. Cassey, O.D.

4590 Edgmont Avenue

Brookhaven, Pa. 19015

In accordance with federal HIPAA regulations we are required to release information to your primary doctor (for HMO plans) and/or your insurance company. Our office will only release information to individuals specifically designated by our patients. If you wish to designate any person(s) to access your information please list them below:

_____ _____

Name Relationship

_____ _____

Name Relationship

Do we have permission to leave voicemail messages? ____Yes ___No

Limited health information may be released by fax with a verbal release (social security number may be required to verify identity). Your signature below acknowledges that you are allowing Dr. Cassey and his designees to disclose and/or discuss any and all medical and financial information in our possession with any individuals who may be listed above. This authorization will remain in effect until termination with current insurance or, for minors, until they reach age of majority.

_____ _____

Signature (Minors must have Parent/Guardian) Date

Please provide an Emergency Contact:

_____ _____

Name Phone #