# Miramar
EYE INSTITUTE

**Surgery and Diseases of the Eye** **Kenneth O. Karp, M.D.**

## Consent for Disclosure of Medical Information
## (Permiso para divulgar su condición médica)

I, _____, hereby allow and give consent for the following family members, friends, or health care surrogates to accompany me in the exam room during my visit or discuss my health information with the physician:

Yo, _____, autorizo a los siguientes familiars, amistades o personas a cargo de mi bienestar, a presenciar o discutir mi condición de salud durante mi visita con el médico:

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

May we leave a message on your answering machine, cell phone, or with the person that answers the phone?
(Nos permite dejar un mensaje en su grabadora, cellular, o con la persona que conteste el teléfono?)

_____ YES (SI) _____ NO

_____ _____
Signature of Patient or Guardian Date/Fecha
(Firma del paciente o guardian)

_____
Signature of Witness/ (Firma del Testigo)

**1951 S.W. 172nd Ave. # 301**
**Miramar, FL 33029**