PATIENT COMMUNICATION FORM

It is the policy of Pacific Northwest Eye not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the individual is entitled to receive information regarding your treatment during this visit), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please indicate below the names of individuals to whom you ***AUTHORIZE*** Pacific Northwest Eye Associates to provide information regarding your medical care.

Name/Contact Number _____ Relationship to Patient _____

Name/Contact Number _____ Relationship to Patient _____

If there are any individuals who SHOULD NOT have access to information regarding your medical care, please identify them below

Name _____ Relationship to Patient _____

What is the best way for our staff to communicate with you regarding your medical care?

❒ Home Phone ❒ Cell Phone ❒ Email ❒ Other: _____

May we leave a message on your voicemail/answering machine?

❒ Yes ❒ No

Name of Patient or Personal Representative (Print) _____ Medical Record # _____

Signature of Patient or Personal Representative _____ Date _____

FOR OFFICE USE

Changes to above authorized by patient over phone (ID Verified):

Change _____ Date _____ Staff Initial _____