FAMILY AND FRIENDS AUTHORIZATION

MEDICAL EYE CENTER

In order to discuss or disclose any medical information to your family or friends we must have a signed consent on file allowing Medical Eye Center, Laser and Surgical Eye Center, Medical Eye Center Optical, or Renew Medical Spa to share information about your care at our office with your family members or friends. Please list the names of those you would like to involve in your health care. This information can be changed or revoked at anytime with your permission.

Patient Name _____ Acct #_____

- ❑ I decline to have my medical information discussed with family or friends.
- ❑ I authorize my medical information to be shared with the following:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize Medical Eye Center, Laser and Surgical Eye Center, Medical Eye Center Optical and Renew Medical Spa to share information related to my health status to the individual(s) listed above.

I understand this might include such information as: diagnosis, prognosis and treatment plans, medications, test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care.

_____ _____

Patient Signature Date

(OVER)

PHONE MESSAGE AUTHORIZATION

MEDICAL EYE CENTER

From time-to-time in caring for our patients, it may be necessary or desirable to contact patients by phone. When you are not available for us to speak to directly, we like to leave messages when possible.

In order to protect your privacy:

- We will not discuss any medical information with anyone except the patient, legal guardian, or person(s) you have listed on our Family and Friends Authorization Form
- We will not leave any medical information on an answering machine.
- We will not leave any medical information on a voice mail system.
- We will attempt to, as a courtesy, leave a reminder message regarding an appointment.

Unless:

We have your written permission to leave detailed messages for you. If you would like to allow detailed voice messages regarding your medical care, please list those phone numbers, check and sign the appropriate section below.

If you do not want to allow detailed voice messages regarding your medical care, please check and sign the appropriate section below.

❑ I DO CONSENT TO LEAVE DETAILED MESSAGES:

I authorize Medical Eye Center, Laser and Surgical Eye Center, Medical Eye Center Optical and Renew Medical Spa to leave phone messages regarding my medical care at the following phone numbers:

Home phone answering machine _____

Work phone voicemail _____

Cell phone voicemail _____

❑ I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I wish to be contacted personally. I do not authorize detailed messages regarding my medical care be left on an answering machine, voice mail, or with anyone else.

Signature: _____ Date: _____

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