



**PATIENT COMMUNICATION FORM**

A. Family and friends. It is the office policy of Richens Eye Center 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 reasonable infer from the circumstance (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitle to receive information regarding your treatment),(iv) in emergence situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to provide to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____	_____yes	_____no
Parent: _____	_____yes	_____no
other: _____	_____yes	_____no
_____	_____yes	_____no
_____	_____yes	_____no

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: \_\_\_\_\_  
 \_\_\_\_\_

Printed Name: \_\_\_\_\_

Patient/Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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 FOR OFFICE USE

Changes to above were authorized by patient over phone:

Change:	Date:	Staff Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____