Chester County Eye Care Associates, P.C.
http://chestercountyeyecare.com/

PATIENT DISCLOSURE AUTHORIZATION

With your permission, we can provide information to you in a variety of ways. Please indicate agreement with the following list by checking all that apply:

Date: _____

Patient Name:_____ _____
Printed Signature

☐ It is acceptable for you to leave information on my answering machine, including appointment reminders.

*Phone Number _____

☐ I do not want you to speak with any family members or friends regarding my condition.

☐ It is acceptable for you to speak with only the following family members/friends regarding my condition: (please check all that apply):

☐ Spouse (please indicate name) _____
(Phone Number) _____

☐ Sibling (please indicate name) _____
(Phone Number) _____

☐ Children (please indicate name) _____
(Phone Number) _____

☐ Friend (Please indicate name) _____
(Phone Number) _____

☐ Other (Please indicate name) _____
(Phone Number) _____

Any additional persons, please list on back of form.

It is the patient's responsibility to notify the office staff of any changes to this Authorization.