CENTER FOR
ADVANCED EYE CARE

CONSENT FOR DISCLOSURE

I understand that my healthcare information at Center for Advanced Eye Care is protected, and I have received a copy of their Patient Notice of Privacy Practices.

For Center for Advanced Eye Care to leave detailed messages on my voicemail or answering machine, I need to give permission to Center for Advanced Eye Care to do so.

CONSENT FOR LEAVING MESSAGES

I consent to information regarding my or my child's (under the age of 18) test results or detailed appointment reminders/instructions be left on my voicemail or answering machine. I understand that "sensitive" information as noted below will be excluded.

Patient Initials	

CONSENT FOR SHARED INFORMATION WITH FAMILY AND FRIENDS

I wish family members or friends to have access to my health care information. Name(s) listed below are family members to whom I grant access to my healthcare information through limited verbal disclosures.

Patient Initials	

NAME	RELATIONSHIP

I understand that some information is considered "sensitive". I understand that I must check the specific boxes in order for my provider, or his/her designee, to release any "sensitive" information.

- ☐ Mental Health/Psychiatric Disorders (including depression)
- ☐ Chemical Dependency (drug and/or alcohol abuse/treatment)
- ☐ Pregnancy Information
- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS Virus

Patient Name (Print)	Date of Birth
Patient Signature	Date

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up-to-date.