EYE CARE CENTER OF LAKE COUNTY, LTD.

Patient name: ____ Date of birth:__________________

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Eye Care Center of Lake County, Ltd. 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 that person is entitled to receive information regarding your treatment), (iv) in emergency 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 be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. **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).

□ Spouse-(name):____ Phone:____________________

□ Mother -(name):____ Phone:___________________

□ Father- (name):____ Phone:___________________

□ Adult Child- (name):____ Phone:___________________

□ Adult Child- (name):____ Phone:___________________

□ Adult Child- (name):____ Phone:___________________

□ Other:________________________________ Relationship:_____________ Phone:___________________

□ School:_____________________________ Contact_________________ Phone:___________________

□ Employer:_________________________ Contact:_________________ Phone:___________________

____ __________________________

Patient or Parent/Guardian (if minor) signature Date

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Printed name of person signing form if not the patient

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Form updated 1-1-16