Alternative Contact/Preferred Method of Communication Form

Patient Name_____Date of Birth_____

We at Eye Doctors of Washington take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____I do NOT authorize anyone to receive information regarding my medical care.

_____I authorize my physician and the employees of this clinic to speak with:

1. _____(Name), my _____(Relationship to patient), their phone number is: _____, regarding my APPOINTMENTS AND ACCOUNT/BILL
2. _____(Name), my _____(Relationship to patient), their phone number is: _____, regarding my MEDICAL CARE AND TREATMENT (including Test Results and Lab Results).

Electronic Communication is my preferred method ☐ **yes** ☐ **no**

(In order to electronically communicate with you or anyone you designate; we are required to have your written permission. Communication may be in the following forms: Home Phone/Answering Machine, Cell Phone: Voicemail, Cell Phone Text-Messaging, E-mail, Mail, or Work Phone.)

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____ TIME: _____