Communication Permissions

Patient Name_____ **Date of Birth**_____

This document does not serve as authorization to release records.

Infocus Eye Care is authorized to leave a voicemail for the following reasons:

☐ Medical Information ☐ Billing Information ☐ Appointment Reminders
☐ All of the Above ☐ None of the Above

Infocus Eye Care is authorized to communicate via text: ☐ Yes ☐ No

Infocus Eye Care is authorized to email newsletters and information regarding my care: ☐ Yes ☐ No

Email Address: _____

I authorize Infocus Eye Care to verbally communicate with the following people:

Person 1:

Name: _____ Relationship: _____

Phone Number: _____

This person is authorized to:

☐ Discuss all information ☐ Schedule or cancel appointments ☐ Other: _____

Person 2:

Name: _____ Relationship: _____

Phone Number: _____

This person is authorized to:

☐ Discuss all information ☐ Schedule or cancel appointments ☐ Other: _____

If you would like to add more than two people, you may use the back of this form.

This authorization may be revoked in writing at any time, it will remain in effect until that time.

Signature (Patient/Legal Guardian):_____ Date:_____

Print Name: _____