Patient Name (PLEASE PRINT): ____________________________ Date of Birth: ____________

PATIENT COMMUNICATION

It is the policy of Retina & Vitreous Center of Southern Oregon, PC 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 (i.e. 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 you will need or want your medical information to be provided to family members, friends or others, please indicate below so 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 or remove names at a later date, please notify our office.

Name	Relationship to Patient	Phone Number

FOR OFFICE USE: Changes to above authorized by patient over phone:

Change	Date	Staff Initials

Alternative Communications: You are also entitled to specify alternative, reasonable means of communication if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:

____

____

______________________________ ______________
Patient Signature Date

OR

______________________________ ______________________________ ______________
Person Authorized by Law (PLEASE PRINT) Signature / Relationship to Patient Date

Rev 10/2013