PATIENT CONFIDENTIALITY

It is the policy of Premier Eye Care Group, Inc. not to release confidential and/or unauthorized information to unauthorized people by telephone, voice messages, cell phone/pager, or email without the consent of the patient.

I understand that I will receive correspondence through the US MAIL and I authorize Premier Eye Care Group, Inc. to leave scheduling or medical information pertaining to my care by the following methods or with the following authorized individuals:

Patient name (please print) _____

Telephone

Home	yes	no	_____
Work	yes	no	_____
Cell/pager	yes	no	_____

Voice messages: yes no

Email yes no _____

Please list names and relationship of authorized people (eg: spouse, parent, child)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

(List additional names on the back of this page.)

I assume responsibility to notify Premier Eye Care Group, Inc. when this information changes.

Signature
Patient or Guardian _____ Date _____