Alternative Contact/Preferred Method of Communication Form

Patient Name_____Date of Birth_____
We at Milauskas Eye Institute 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 employee of this clinic to speak with:

1. Person:_____ Relationship:_____
   Phone number(s): _____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

2. Person:_____Relationship:_____
   Phone number(s): _____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

3. Person:_____Relationship:_____
   Phone number(s): _____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

Please check your primary and secondary preferred methods of communication:

_____Home Phone/Answering Machine _____Mail _____Work Phone

_____Cell Phone (voice mail) _____Cell Phone (text message)

_____Email and email address _____

Electronic Communication is my preferred method ☐ **yes** ☐ **no**
(In order to electronically communicate to you or anyone you designate, we are required to have your written permission).

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: _____

WITNESS SIGNATURE: _____

DATE: _____ TIME: _____

MILAUSKAS EYE INSTITUTE
The Desert's Leader in Eye Care