Associates in Eyecare

I hearby give permission for the following person or persons listed below(example:parents, spouse, children, relatives, significant other, etc.) to receive information regarding my medical care(example: appointment times, test results, medications, etc.) **IF THEY ARE NOT LISTED, WE CANNOT GIVE OUT ANY INFORMATION TO THEM.** You may add or delete anyone at any time. This permission will be solely used by Associates in Eyecare and Dr. Susan M. Perdue

PATIENT'S PRINTED NAME PATIENT' DATE OF BIRTH

NAME RELATIONSHIP PHONE NUMBER

NAME RELATIONSHIP PHONE NUMBER

NAME RELATIONSHIP PHONE NUMBER

NAME RELATIONSHIP PHONE NUMBER

NAME RELATIONSHIP PHONE NUMBER

NAME RELATIONSHIP PHONE NUMBER

_____ I **do not** want anyone to receive information regarding my medical care.

PATIENT/GUARANTOR SIGNATURE DATE