TEXAS OPHTHALMIC PLASTIC, RECONSTRUCTIVE & ORBITAL SURGERY ASSOCIATES

PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMMUNCATION OF HEALTH INFORMATION

WHO TO CONTACT

I HEREBY GIVE PERMISSION TO TEXAS OPHTHALMIC PLASTIC, RECONSTRUCTIVE & ORBITAL SURGERY ASSOCIATES TO DISCLOSE AND DISCUSS ANY INFORMATION RELATED TO MY MEDICAL CONDITION(S) WITH THE FOLLOWING PEOPLE:

|  |  |  |  |
| --- | --- | --- | --- |
| NAME |  | RELATIONSHIP |  |
| NAME |  | RELATIONSHIP |  |
| NAME |  | RELATIONSHIP |  |
| NAME |  | RELATIONSHIP |  |
| NAME |  | RELATIONSHIP |  |

--------------(initial) I DO NOT WISH TO GIVE PERMISSION FOR ADDITIONAL FAMILY MEMBERS, RELATIVES OR CLOSE PERSONAL FRIENDS TO HAVE ACCESS TO ANY INFORMATION REGARDING MY MEDICAL CONDITION(S).

HOW TO CONTACT

PREFERRED METHOD OF COMMUNCATION?

\_\_\_\_ HOME PHONE \_\_\_\_\_\_ CELL PHONE

\_\_\_\_ WORK PHONE \_\_\_\_\_\_ EMAIL

\_\_\_\_ FAX

EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ OK to leave message with detailed information

\_\_\_\_ Leave a message with call-back number only.

PRINT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_