EYECARE PROFESSIONALS
& MOUNTAIN EYEWEAR

Verbal Communication Authorization Form

Print Patient Name: _____

Date of Birth: ____/_____/_____

Please list any family members or other individuals who may be involved in coordinating your care, or payment for your care. Please indicate what types of information may be shared with each individual.

Name _____

Phone # _____ Relationship _____

Type of Information ___ All ___ Scheduling ___ Medical ___ Billing

Name _____

Phone # _____ Relationship _____

Type of Information ___ All ___ Scheduling ___ Medical ___ Billing

Name _____

Phone # _____ Relationship _____

Type of Information ___ All ___ Scheduling ___ Medical ___ Billing

____ Check here if NO ONE is allowed to call about any of your information.

Specific instructions or limitations: _____

_____

We will rely on the information on this form when communicating regarding your care unless you request changes. Please notify our office if you wish to alter the above designations. Signed original will be placed in your medial record.

To revoke this authorization, please send a written request to: Eyecare Professionals, 305 W Park St., Livingston, MT 59047

Signature of Patient or Guardian: _____

Relationship to Patient: _____ Date: _____/_____/_____