Name: ______________________________________ **Date:** ____________________

CONSENT TO LEAVE A MESSAGE/SHARE INFORMATION WITH FAMILY

□ I consent to information regarding my or another family member's detailed appointment reminders/instructions be left on my voice mail or answering machine. I understand that sensitive information as noted below will be excluded.

Consent for shared information with family

□ I wish family members to have access to my health care information. The name(s) listed below are family members to whom I grant access to my health care information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary.

	Name	Relationship
1.	______________________________	____________________
2.	______________________________	____________________

XPatient Signature: ____

Patient/Parent Signature

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It is my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

NOTICE OF PRIVACY PRACTICES:

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES of Retina EyeCare.

XPatient Signature: ____

NOTICE OF FINANCIAL POLICY:

I acknowledge receipt of the FINANCIAL POLICY OF Retina Eyecare.