CAPE REGIONAL EYE CENTER

AUTHORIZATIONS AND NOTIFICATIONS

Initials

_____ I authorize Cape Regional Eye Center to contact :

(printed name)_____

@ (phone)_____ for the purposes of notifying me of my protected health information such as test results, appointment dates and times, or other necessary business. This person will be notified when I cannot be reached. I also understand that this contact has the potential to break confidentiality to which I agree. I understand that if I do not want anyone listed to contact, I may make arrangements to have all contacts regarding medial issues conducted at our office.

_____ I, or my authorized legal representative, hereby give consent to Cape Regional Eye Center to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

_____ By signing this paper I give permission for doctors and nurses to discuss diagnosis and treatment in front of the person and/or persons accompanying me in all examination and treatment areas of Cape Regional Eye Center and Cape Surgery Center.

_____ I acknowledge that I may request a copy of the Cape Regional Eye Center's Notice of Privacy Practices and a copy is available for me to view in the waiting room.

_____ Date of Birth_____ Today's Date_____

Printed Name of Patient

_____ _____

Signature of Patient Signature of Patien'ts Representative or Witness