Niagara Eye Associates
1801 West 8th Street
Erie, Pa. 16505
814-455-8004 Fax: 814-456-6054

Niagara Eye Associates
Personal Communicaton of Your Patient Information

NAME_____ **Date of Birth**_____

There may be times when we would like to informally contact you with information, or when you may want us to tell others, such as family or friends, about your condition or treatment. For instance, we may need to contact you to report test results or you may want us to inform your family of how your treatment is proceeding. We refer to this type of informal communicaton as "Personal Communication". Please fill out this form to help guide us in providing Personal Communication about you.

Niagara Eye Associates has my permisson to Bill my Insurance: YES_____ or NO_____

1. Please indicate who else (if anybody) we may communicate with concerning your condition and/or treatment?

____No one
____My Spouse, please print name:_____
____My Children, please print name:_____
____My Parent(s) please print name:_____
____Others: _____

Emergengy Contact Person, please print name: _____

Number of Emergency Contact:_____

2. May we provide Personal Communication to you by telephone?

___ Yes ___No

If yes, please list the telephone number we may use, if it is other than what we currently have on file: _____.

3. If you are not available when we call by telephone, may we provide the information to the person who answers, or leave the information on the answering machine?

___Yes ___No

4. If we use regular mail to provide Personal Communication to you we will use the address you have given us. If you want us to use an address different than what we have on file, please list it here:

_____

_____

5. May we provide appointment reminders by means of texting.

___Yes ____No If Yes cell number: _____

6. May we provide appointment reminders by means of e-mail.

___Yes ____No If Yes e-mail address:_____

7. If there are any other specific requests for restriction on Personal Communication that you would like to make, please note them here:

_____

_____

8. This form will remain in effect for the following terms:

____As Long as I am a patient____This treatment & follow up only___Other: _____

I understand the following with respect to this form:

- I may refuse to complete/sign this form. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- If the person(s)receiving information about me through Personal Communication is not a health care provider or a health plan covered by Federal Privacy Regulations, the information may be re-disclosed and no longer protected by Federal Privacy Regulations.
- I may change or revoke this form in writing at anytime, for future Personal Communications.

_____ _____

Signature of patient or patient's legal representative Date

_____

Print patient's name

_____ _____

Print name of legal representative (If applicable) Relationship to patient