

### Alternative Contact/Preferred Method of Communication Form

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
We at WK Zaffater Eye Center take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

\_\_\_\_\_ I do NOT authorize anyone to receive information regarding my medical care.

\_\_\_\_\_ I authorize my physician and the employee of this clinic to speak with:

1. Person: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone number(s): \_\_\_\_\_

Appointments  Account/Bill  Lab Results  Test Results  Medical Care  Treatment

2. Person: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone number(s): \_\_\_\_\_

Appointments  Account/Bill  Lab Results  Test Results  Medical Care  Treatment

3. Person: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone number(s): \_\_\_\_\_

Appointments  Account/Bill  Lab Results  Test Results  Medical Care  Treatment

**Please check your primary and secondary preferred methods of communication:**

\_\_\_\_\_ Home Phone/Answering Machine \_\_\_\_\_ Mail \_\_\_\_\_ Work Phone

\_\_\_\_\_ Cell Phone (voice mail) \_\_\_\_\_ Cell Phone (text message)

\_\_\_\_\_ Email and email address \_\_\_\_\_

**Electronic Communication is my preferred method**  **yes**  **no**

(In order to electronically communicate to you or anyone you designate, we are required to have your written permission).

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form.

Any problems and/or questions concerning this form are to be referred to the Willis-Knighton Health Systems Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

PATIENT SIGNATURE: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_