

KENTUCKY EYE INSTITUTE CONSENT FOR PATIENT CONTACT

From time to time, it may be necessary for Kentucky Eye Institute to contact you concerning a variety of issues that pertain to your medical care. While the following list is not all-inclusive, we might need to contact you to:

- Make an appointment
- Cancel an appointment
- Inform you that your glasses or contact lenses are ready to be picked up
- Discuss your medical care and treatment
- Etc.

To assist you with your needs and to address the patient privacy issues described in the Health Insurance Portability and Accountability Act of 1996, we need you to specify the alternative ways we may contact you in the event we cannot reach you personally.

You may contact me by: (please check any box(es) that apply)

- Leaving a message on my home answering machine
- Leaving a message on my work answering machine
- E-mailing me at home _____
- E-mailing me at work _____
- Leaving a message with anyone who answers my telephone at home
- Leaving a message with anyone who answers my telephone at work
- U.S. mail
- Other (specify): _____

In the event you cannot contact me personally, you may discuss my care with any of the following individuals:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

No one

I give my consent for any representative of KEI to contact me regarding my care using the means I have indicated by the checked boxes above. Further, I give my permission to discuss my care with the individuals whose names are listed.

Patient's Signature

Date