PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Clearview Eye and Laser, PLLC not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the box under the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later please confirm this in writing, or call our staff.)

	YES	NO
Spouse: _____	☐	☐
Parent: _____	☐	☐
Other: _____	☐	☐
_____	☐	☐

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

_____

Ok to leave a detailed voicemail ☐ Cell phone ☐ Home phone

I consent to receive appointment reminders (Data rates may apply) ☐ Text/SMS ☐ Email

Patient/Parent/Guardian Signature _____ Date: _____

PRINTED NAME _____ **DOB:** ____/____/____

FOR OFFICE USE

Changes to above, authorized by patient.

Change	Date	Staff
_____	_____	_____
_____	_____	_____
_____	_____	_____

Updated 04/02/2026