Alternate Contact & Release of Information

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Physician and Surgeon
Ophthalmologist

VALLEY EYE & LASER

Patient Name _____ **Home phone**_____

Patient DOB _____ **Work/ Cell phone** _____

I. Contact Information and Consent

Valley Eye Center has my consent to:

❑ Yes	❑ No	❑ N/A	Leave medical information on voicemail at home
❑ Yes	❑ No	❑ N/A	Leave medical information on my personal cell phone
❑ Yes	❑ No	❑ N/A	Contact and/or leave medical information at my place of employment
❑ Yes	❑ No	❑ N/A	Leave medical information on family/guardian/caregiver's voicemail
❑ Yes	❑ No	❑ N/A	Discuss medical information with approved family/guardian/caregiver's

Note: Voicemail messages will not be left if the greeting does not include name or phone number

II. Family/Friends Release of Information

I authorize Valley Eye Center to discuss any information regarding my health and medical care with the below mentioned family member(s), guardian(s) and/or caregiver(s):

Name	Relationship	Phone number

Signature _____ **Date**_____

This authorization is valid until revoked by the patient orally or in writing at any time.