PLEASE PRINT LEGIBLY **Geneva Eye Clinic, Ltd.**

Patient Name: _____

It may be necessary for the office to leave a message for you regarding medical information such as test results, prescriptions, billing or account information or other health care issues.

Can we leave a message on your:

Home Phone: ☐ **Yes** ☐ **No** **Number:** _____

Work Phone: ☐ **Yes** ☐ **No** **Number:** _____

Cell Phone: ☐ **Yes** ☐ **No** **Number:** _____

Please list every family member or friend who is authorized to speak with us about your health care issues. This includes spouses, children or parents.

Remember that if anyone calls us with a question, we will not be able to speak with them unless they are listed here.

Name	**Relationship**	**Phone Number**
Name	**Relationship**	**Phone Number**
Name	**Relationship**	**Phone Number**

This will remain in effect until it is revoked in writing.

Patient Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of the Geneva Eye Clinic's Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____

_____
If not patient, state relationship