ANDERSEN EYE ASSOCIATES

I hereby give permission for the following person or persons listed below (example: parents, spouse, children, relatives, significant other, etc.) to receive information regarding my medical care (example: appointment times, test results, medications. etc.). ***IF THEY ARE NOT LISTED, WE CANNOT GIVE OUT ANY INFORMATION TO THEM.*** You may add or delete anyone at any time. This permission will be solely used by Andersen Eye Associates.

_____ _____
PATIENT'S PRINTED NAME **PATIENT'S DATE OF BIRTH**

_____	_____	_____
NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
NAME	RELATIONSHIP	PHONE NUMBER

_____ I **do not** want anyone to receive information regarding my medical care.

_____ _____
PATIENT / GUARANTOR SIGNATURE **DATE**

G:consents/permission/revised 7/12/07