Request for Electronic Communications

Name of Patient: _____

Date of Birth: _____

I request that the following communications from Precision Eyecare Centers be delivered to me by the provided electronic mean(s).

I ☐ allow/ ☐ do not allow having a detailed voicemail left via my home phone for appointment reminders or test results by Precision Eyecare Centers:

My phone number is: _____.

I ☐ allow/ ☐ do not allow for Precision Eyecare Centers to leave detailed messages in regards to appointments, results or reminders with whoever answers the phone.

I ☐ allow/ ☐ do not allow having detailed email messages left via my email address for appointment reminder or test results by Precision Eyecare Centers.

My email address is: _____.

I understand that emails received on my personal email address may not meet the required HIPAA security level. I understand that others who have access to my personal email my read, review or intercept the email prior to me reviewing the email. _____ (initial)

I ☐ allow/ ☐ do not allow Precision Eyecare Centers to use my cellphone number to (choose one or both) ☐ call or ☐ text regarding appointments and to ☐ call or ☐ text regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

My cellphone number is (include area code): _____.

Acknowledgement and Agreements:

I understand and agree that the requested communication methods may not be secure, making my protected health information at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against Precision Eyecare Centers in any way should this occur.

Signature of Patient: _____ Date: _____

Print Name: _____ Phone Number: _____

Address: _____

Print Name of Personal Representative: _____

Relationship to the Patient: _____

Signature of Personal Representative: _____

Date: _____