ACKNOWLEDGEMENT OF
CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

.

Stone Oak Ophthalmology Center
Lifelong Comprehensive Eye Care

Date: _____

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY HEALTH APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Email Confirmation
- ☐ U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY HEALTHCARE HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Email Message
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW HEALTH INFO** via:

- ☐ Phone Message
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**