

Telephone List

Please provide the name(s) of any person(s), to whom you would like our office to allow disclosures of personal information. Please also specify information that may be disclosed (i.e.: test results, appointment information, payment information, patient's prescription, ordering of contact lenses and/or glasses, etc.) You may also indicate "All" if appropriate.

Name	Relationship/Contact Phone Number	Allowed Disclosures
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

I, _____ hereby acknowledge that I have received a copy of your Notice of Privacy Practices.

Patient/Guardian Signature

Date

Printed Name