PASCO VISION CLINIC

Patient Name: _____

By signing below, I give permission to the person(s) listed in the table documented to receive information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continued care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed medical release. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	Name of Individual	Relationship to Patient	Type of information to be released

THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

- ☐ Leave a message at home with my spouse or: Name: _____
  Relationship: _____
- ☐ Leave message on cell phone Cell phone number: _____
- ☐ Leave message at work Work phone number: _____
- ☐ Leave a message on voicemail Phone number: _____

Signature of Patient _____

Signature of Guardian _____
(If the patient is a minor)

Date _____