AESTHETIC EYE ASSOCIATES, PS DBA ALLURE LASER CENTER & MEDISPA
425-216-7200

Communication Agreement

Patient Name _____Date of Birth_____

Your Healthcare Provider may need to contact you to discuss your health, review results of testing or to coordinate your care. Please review and answer a few questions regarding your preferences regarding this communication.

1. May we leave messages regarding your health information on your answering machine or voicemail at **home**? _____**NO** _____**YES** _____**N/A**

2. May we discuss your medical care with **anyone** that answers the telephone at your home? ____**NO** _____**YES** _____**N/A**

3. May we leave messages regarding your health information on your answering machine or voicemail at **work**? _____**NO** _____**YES** _____**N/A**

4. May we leave messages regarding your health information on your **cellular** telephone voicemail? _____**NO** _____**YES** _____**N/A**

5. May we communicate with you via your e-mail. If yes may we have your e-mail address:

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6. Can we include you on our mailing list for promotional information ___NO ____ YES

7. May we call regarding appointment changes/confirmations?

At Home	___NO	____YES
At Work	___NO	____YES
Cell Phone	___NO	____YES

8. Are there any members of your family, household or those coming with you to this Appointment with which we should **not** discuss any of your health care issues?
_____**NO** _____**YES** _____**N/A**

Explain:_____
_____
_____

I AGREE that I am making this request for my convenience, without coercion or pressure by my healthcare provider or any other party. I understand that this request may result in someone other than me learning of my personal health information. I also understand that this agreement will be in place until I personally request in writing that it be cancelled. I will be responsible for completing a new request form to update contact numbers should they change. If my contact numbers should change, I give permission to send test results to me by mail.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent or legal representative)

Please list additional phone numbers:_____
_____