Eyes For Life

Patient Privacy Agreement

I, _____, agree that the *Eyes For Life Notice of Privacy Practices* has been made available to me.

Eyes For Life has been given permission to contact _____ (ex: friend or family member who may answer your phone, pick up orders or schedule for you) on my behalf regarding all billing and medical concerns as needed. This authorization will stay in effect until I revoke it.

Check Those That Apply:

♢ I am a patient at Eyes For Life.

♢ I am a parent or guardian of _____, a patient at Eyes For Life.

♢ I am a representative of _____, a patient at Eyes For Life.

Signature: _____ Date: _____