



**I received the Notice of Privacy Practices from Cavanaugh Eye Center, PA.**

\_\_\_\_\_  
Patient Initial

**I hereby allow Cavanaugh Eye Center, PA, to disclose the following protected health information:**

- Appointment dates and times
- Examination findings
- Test results
- Other health information

**To the following people because they are directly involved with my health care or payment for my medical services (please check and write in name(s) of designees):**

- Self
- Spouse \_\_\_\_\_
- Family Friend \_\_\_\_\_
- Child \_\_\_\_\_
- Other \_\_\_\_\_

**In the following forms of communication:**

- Home Telephone \_\_\_\_\_
- Work Telephone \_\_\_\_\_
- Home Voice Messaging System \_\_\_\_\_
- Work Voice Messaging System \_\_\_\_\_
- Cellular Phone \_\_\_\_\_
- E-Mail \_\_\_\_\_

**\_\_\_ I authorize Cavanaugh Eye Center, PA, to send medical and/or surgical patient education information to me by the email address I have provided.**

**\_\_\_ I authorize Cavanaugh Eye Center, PA, to send a "Thank You" note to the friend/relative that referred me to this office.**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient/Guardian Signature