Gabrielle Family Vision Care
11411 NE 124th St
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Kirkland, WA 98034

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Communication Agreement

Patient Name (LAST, First): Patient's DOB (Month/Day/Year):

Gabrielle Family Vision Care may need to be in contact to discuss the patient's health, to review results of testing, or to coordinate specifics of care. Please review and answer a few questions regarding the preferences for this communication. This is for the patient's and family's convenience so that we can contact them effectively. Please note we will use the contact information given on the patient's registration form so please make sure all information is easy to read.

1. May we leave messages regarding the patient's health information on voice mail at **HOME**?	Yes ❑	No ❑
2. May we leave messages regarding the patient's health information on voice mail at **WORK**?	Yes ❑	No ❑
3. May we leave messages regarding the patient's health information on voice mail with **CELL-PHONE**?	Yes ❑	No ❑
4. Many patients prefer email to communicate appointment changes, results of exams and testing, reminders, discussions of health, specifics of care, etc. May we **EMAIL**?	Yes ❑	No ❑

5. Please print the **Primary Email Address** to be used for our automated reminder system: (Note: Only this email will be used)

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6. With whom may we discuss the patient's detailed health information?

(i.e.: Family members such as Spouse, Grandparents, Siblings, etc. / Other Health Care Providers)

I agree that I am making this request for my convenience, without coercion or pressure by my health care provider or any other party. I understand that this request may result in someone other than myself 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.

Signature of Patient or Responsible Party	Print Name of Responsible Party / Relationship	Date (M/D/Yr)	Staff Initials	Date (M/D/Yr)