PREMIER
Eye Care & Surgery, Ltd

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Cataract, Micro Incision
Glaucoma, SLT Laser
Refractive Surgery
CustomVue, Wavefront
Lasik, PRK, PTK
Pediatric Ophthalmology
Adult Strabismus
Specialty Contact Lenses

PREFERRED METHOD OF COMMUNICATION WITH WHOM WE MAY COMMUNICATE

ACCOUNT#_____ **DOB:**_____

PATIENT NAME:_____

PATIENT EMAIL :_____

Please **CIRCLE** your preferred method of communication (other than appointment reminders).

Phone Email Letter (We will try to accommodate all reasonable requests)

Please list below any individuals with whom we may share your health information. We will share only information that is directly relevant to the individual's involvement with your healthcare.

NAME:_____**RELATIONSHIP:**_____

Email:_____

NAME :_____**RELATIONSHIP:**_____

Email:_____

NAME:_____**RELATIONSHIP:**_____

Email:_____

NAME:_____**RELATIONSHIP:**_____

Email:_____

I understand that I have the right to withdraw this consent at any time. My withdrawal must be in writing. Any withdrawal will be valid except for the release of information that occurred prior to this consent being withdrawn. For information on how to withdraw this consent contact the office at 847-459-6060.

This consent will not expire unless otherwise indicated.

If you wish Premier Eye Care & Surgery, LTD to release any written documents to another individual, you will need to complete an Authorization for Release of Information form.

Signature:_____**Date:**_____

Printed Name:_____**Witness:**_____