SPRINGFIELD EYE ASSOCIATES, INC.

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CONSENT TO DISCLOSE INFORMATION

Patient Name: _____ DOB _____

I give Springfield Eye Associates, Inc. permission to speak to the following person(s) - family or friend(s) - should they call on my behalf to inquire about my eye condition, billing questions, or appointments.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____

EMERGENCY CONTACTS

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____

Patient Signature _____ Date _____

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Or Verbal Authorization taken by Springfield Eye Associates Staff Member _____

This document expires (1) year from the date signed.