



# SPRINGFIELD EYE ASSOCIATES, INC.

3640 MAIN STREET • SUITE 205 • SPRINGFIELD, MASSACHUSETTS 01107-1145 • TEL. (413) 739-7367 • FAX (413) 737-2686

PHILIP MORAITIS, M.D.  
SARAH A. HANSON, M.D.  
BRIAN BREDVIK, M.D.

MATTHEW C. KIDD, O.D.  
KIMBERLY CASTELLANOS, O.D.

## PATIENT 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.**

<u>NAME</u>	<u>RELATIONSHIP TO PATIENT</u>
_____	_____
_____	_____
_____	_____

## EMERGENCY CONTACT(S)

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>PHONE NUMBER</u>
_____	_____	( ) _____
_____	_____	( ) _____

### Regarding Messages (please check all that apply)

\_\_\_ I authorize you to leave a detailed message on my \_\_\_\_\_ home or \_\_\_\_\_ cell number regarding appointments

\_\_\_ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

\_\_\_ I authorize you to leave a message with anyone who answers the phone

\_\_\_ Messages may only be left with \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.**

\*\*\*\*\*

**Verbal authorization given by patient after verification of patient identity by Staff Member:** \_\_\_\_\_

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