

**Mountain Empire Eye Physicians, PLLC**  
**Mountain Empire Cataract & Eye Surgery Center**  
**Mountain Empire Hearing and Audiology Services**

In order to protect the privacy and confidentiality of your protected health information Mountain Empire Eye Physicians and Mountain Empire Cataract & Eye Surgery Center and their staff members are requesting your permission to provide information to individuals other than yourself.

**I agree/disagree** that information directly related to my healthcare and billing can be released to family members, relatives, close personal friends, or any other person that are identified below.

**I agree/disagree** to be contacted by telephone for appointment confirmations, follow-up, about treatment or test results, in an emergency at work, and that you may leave messages on my answering machine.

Please identify individuals that you agree to allow Mountain Empire Eye Physicians and Mountain Empire Cataract & Eye Surgery Center and their staff members to communicate healthcare and billing information to:

Name \_\_\_\_\_ DOB/Phone # \_\_\_\_\_

Name \_\_\_\_\_ DOB/Phone # \_\_\_\_\_

Name \_\_\_\_\_ DOB/Phone # \_\_\_\_\_

Name \_\_\_\_\_ DOB/Phone # \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or legally authorized individual Date

\_\_\_\_\_  
**Relationship to patient, if signed by anyone other than the patient**  
**(Parent/legal guardian, personal representative, etc.)**

The "Notice of Privacy Practices" for Mountain Empire Eye Physicians and Mountain Empire Cataract & Eye Surgery Center has been made available for my review.

Patient Initials \_\_\_\_\_