green eye center
854 Lone Oak Drive Gallatin, Tennessee 37066

Patient Name:_____

DOB:_____

Dear Patient,

If there is anyone (spouse, relatives, friends, etc.) that may need to contact us regarding your care at Green Eye Center, please write each person's name, phone number and their relationship to you and sign and date below. I give my permission to Dr. Green and staff to discuss my medical condition and treatment as well as information regarding my appointments and my account with the following individuals until I submit changes in writing:

1. _____ _____
Name & Phone # Relationship

2. _____ _____
Name & Phone # Relationship

3. _____ _____
Name & Phone # Relationship

4. _____ _____
Name & Phone # Relationship

I acknowledge that I have received a copy of Green Eye Center's Notice of Privacy Practices which describes how they may use and disclose my Protected Health Information.

_____ _____
Signature of Patient or Guardian Date