

# GREEN EYE CENTER

Michael E. Green, MD  
Stephanie Bestwina, OD

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

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

**GREEN EYE CENTER**

Michael E. Green, MD  
Stephanie Bestwina, OD

I, \_\_\_\_\_, acknowledge that I have  
Print Patient Name

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