CAROLINA CATARACT & LASER CENTER

David T. Vroman, MD
Millin C. Budev, MD
Kristiana D. Neff, MD
Michelle S. Ying, MD

As a patient of Carolina Cataract & Laser Center we may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This form is to acknowledge that you authorize Carolina Cataract & Laser Center to contact you.

How do you prefer to be contacted: (please check all that apply):			
Phone	☐ Yes – Home ☐ Yes - Cell ☐ No	**Ok to leave Voicemail?** ☐ Yes ☐ No	Number:
Email	☐ Yes ☐ No	n/a	Email Address:
☐ None of the above			

How would you like to receive your balance statement from our office?

☐ Email: _____
☐ Text: _____
☐ Mail: _____

PHI Disclosure to Family Members

You may authorize us to contact or to provide information regarding your medical care or financial matters to another person. This is to acknowledge that you authorize Carolina Cataract & Laser Center to disclose your PHI (protected health information) to the following individuals. Please note that unless you specify another party below Carolina Cataract & Laser Center is not allowed to share any information about your account or care with our practice to any other party other than your insurance company or as required by law (check all that apply):

Name: _____ Relationship: _____
Telephone: _____ Email: _____
Types of Information:

- ☐ Appt Reminders
- ☐ Test Results or Exam Notes
- ☐ Financial