CASCADE
Eye & Skin Centers, P.C.

Patient Name: _____ **Patient Account #:** _____

Date of birth: _____

In compliance with our HIPAA policies and procedures we need your specific permission to leave a detailed message regarding: (Please select all that you consent to)

- o Medications / Treatment
- o Labs / Pathology results
- o Scheduling
- o Billing / Insurance
- o Cosmetic Treatment
- o Other: _____

- o **DO NOT LEAVE A DETAILED MESSAGE**

May we leave a detailed message with / on:

- o Your Phone:_____

- o Spouse:_____
  Name Phone Number

- o Family Member:_____
  Name Phone Number

- o Other Contact:_____
  Name Phone Number

Print Name _____

Signature _____

Date_____