CASCADE
Eye & Skin Centers, P.C.

Patient Name: _____ Date of birth: _____

In compliance with our HIPAA policies and procedures we need your specific permission to leave a detailed message regarding:

__ Medications/Treatment __ Billing/Insurance

__ Labs/Pathology results __ Cosmetic Treatment

(Please select all that you consent to)

___ DO NOT LEAVE A DETAILED MESSAGE.

May we leave a detailed message with/on:

- Your Phone:_____

- Spouse:_____

  Name Phone Number

- Family Member:_____

  Name Phone Number

- Other Contact:_____

  Name Phone Number

Printed Name Signature Date