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)

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

- **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

Print Name ____

Signature ____

Date____