St. Cloud Eye Clinic
COMPREHENSIVE EYE CARE FOR OVER 80 YEARS

Patient Confidentiality

Steven W. Rice, M.D., F.A.C.S.
Richard W. Lucius, M.D., F.A.C.S
Bradley M. Anderson, M.D.
Mitchell D. Harstad, O.D.

Patient name (please print) _____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska ☐ Native Hawaiian/Other Pacific Islander

Language: _____ Other Communication Issues: ☐ Yes ☐ No If yes, please list: _____

Native Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown / Not Reported

I understand that I will receive correspondence through the US Mail and I authorize St. Cloud Eye Clinic to leave scheduling or medical information pertaining to my care by the following methods or with the following authorized individuals:

Contact Information:

Home _____ OK to leave a message? ☐ Yes ☐ No

Work _____ OK to leave a message? ☐ Yes ☐ No

Cell _____ OK to leave a message? ☐ Yes ☐ No

How would you like to be contacted regarding your appointments?
☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Text Message

E-mail address _____

It is the policy of St Cloud Eye Clinic not to release confidential and/or unauthorized information to unauthorized people by telephone, voice messages, cell phone/pager, or e-mail without the consent of the patient.

Please list names and relationship of individuals we may release medical information:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

In case of an emergency please contact:

Name _____ Phone Number _____

Name _____ Phone Number _____

I assume responsibility to notify St. Cloud Eye Clinic when this information changes.

_____ _____ _____

Signature of Patient or Guardian | Printed Name of Patient or Guardian | Date