Patient Contact Authorization

Freehold Eye & Vision Care, LLC
555 Iron Bridge Road
Suite #16
Freehold, NJ 07728

I, _____, authorize and give permission to Freehold Eye & Vision Care, or any practice staff members, to leave messages regarding my medical information on the following telephone (s).

Home: _____

Cell: _____

I authorize and give permission to Freehold Eye & Vision Care, or any practice staff members, to speak with the following people regarding my medical status and/or treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Date: _____