Approved Participants of Care

Patient Name: ________________________________
Print

Medical Record Number: _______________________

1. ____________________________ ______________________ __________________
Name (print) relationship telephone no.

2. ____________________________ ______________________ __________________
Name (print) relationship telephone no.

3. ____________________________ ______________________ __________________
Name (print) relationship telephone no.

4. ____________________________ ______________________ __________________
Name (print) relationship telephone no.

5. ____________________________ ______________________ __________________
Name (print) relationship telephone no.

I authorize Lansing Ophthalmology to share my health information with the above named people, only as necessary, to facilitate my care. I will inform Lansing Ophthalmology if I ever wish to add or delete individuals from this list.

________________________________ __________________
Patient Signature Date