

TELEPHONE LIST

Please provide the name(s) of person(s) if any, to whom you would like FOC to allow disclosure of personal information. Please also specify information that may be disclosed (i.e. test results, appointment information, payment information, patient's prescription, ordering of contact lenses and/or glasses, etc. You may also indicate "All," if appropriate).

Name	Relationship/Contact Phone Number	Allowed Disclosure(s)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

I _____, hereby acknowledge that I have received a copy of Fairfax Optometric Center's Notice of Privacy Practices.

Patient/Guardian Signature

Date

Printed Name