CHERRY CREEK EYE PHYSICIANS AND SURGEONS, PC
Stuart A. Lewis, MD

As a patient of our office you have a right to request, disclose or restrict protected health information. Contact between yourself and our office will be confidential according to the protected health information privacy rules. Please choose which means of correspondence that works best for you.

I wish to be contacted in the following manner (check all that apply):

- **Home Telephone**: ______________________

_____ Permission to leave a voice mail message with detailed information.

_____ Permission to leave a detailed message with a family member.

OR

_____ Leave a message with a call back number only.

- **Work Telephone**: ______________________

_____ Permission to leave a message with detailed information.

OR

_____ Leave a message with a call back number only.

- **Written Communication**: ___________________

_____ Permission to mail to my house address.
_____ Permission to mail to my work/office address.
_____ Permission to fax to this number_____________

_____ Other___________________________________

______________________	______________________	_____________
Print Name	Patient Signature	Date