Oxford Family Eye Care
Dr. Malcolm H. Kelly, Jr.
49 South 2nd Street
Oxford, PA 19363

Consent to Communicate Via Email

I understand that authorized personnel from *Oxford Family EyeCare* may communicate with me regarding scheduling, the treatment being provided, educational information including newsletters as it relates to health related products or services available at *Oxford Family EyeCare*, or alternative treatments, locations or providers. I agree to receive such communication via email at the following email address:

_____
Email address

x _____x_____
Patient/Guardian Signature Date

Consent to Communicate to Others

I hereby authorize *Oxford Family EyeCare,* through its appropriate personnel, to communicate with

_____, my

□ husband □ wife □ mother □ father □ son □ daughter

□ significant other □ friend

Regarding billing and payment for services rendered on my behalf. I understand that *Oxford Family EyeCare* will attempt to verify the identity of those I authorize to communicate regarding billing and payment by way of seeking confirmation of the answers to ***at least 2*** of the following questions.

- Patient's mother's maiden name is _____
- City in which the patient was born _____
- Birthday of the patient is (mm/dd/yyyy) _____
- Name of patient's current pet is _____
- Zip code of the patient's mailing address is _____