Marston Optometry
Shea Ferree Carney, O.D.
Carol Marston-Foucher, O.D., F.A.A.O.

I understand that if my protected health information is to be transferred by email, certain risks are inherent to this method of communication.

_____I authorize the use of email for communication.

_____I do not authorize the use of email for communication.

_____ _____
Patient Signature Date

I, _____, grant permission to discuss my care and/or information in my records with the following person(s):

_____ _____
Name Date

_____ _____
Name Date

_____ _____
Patient Signature Date

32037 Plymouth Road • Livonia, Michigan 48150 • (734) 421-5454 • Fax (734) 421-6133