EYE PROFESSIONALS

HIPAA INFORMATION FORM

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/ detailed medical information on voicemail at either of these phone numbers?

☐ Yes ☐ No Home Phone: _____ ☐ Yes ☐ No Cell Phone: _____

May we contact you at your place of employment? ☐ Yes ☐ No

If so, may we leave a message? ☐ Yes ☐ No

Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (appointments, general information, surgical, billing, etc)?

☐ Yes ☐ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? ☐ Yes ☐ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize The Eye Professionals to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from healthcare providers, laboratories, radiology facilities, or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all issues as stated above.

I have reviewed The Eye Professionals Notice Of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

WITNESSED BY: _____