sun valley eye care

Patient Contact & PHI Information Form

Patient's Name: _____ **Date of Birth:** _____

Phone Number:

1. (____) _____ - _____ **Text? ◯Y ◯N ◯Cell ◯Work ◯Home

2. (____) _____ - _____ Text? ◯Y ◯N ◯Cell ◯Work ◯Home

Email:_____**

◯*@Gmail.com* ◯*@Yahoo.com* ◯*@Hotmail.com* ◯*@Outlook.com* ◯*@Aol.com* ◯*@iCloud.com* ◯@_____

Address:_____

City, State, Zip:_____

Gender: ◯F ◯M ◯Other: _____

I authorize the following person(s) to receive Private Health Information (PHI) pertaining to my medical care other than myself or any Physician involved in my care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Restriction of Private Health Information - Extremely Important Information:

If there is someone, such as a parent, that is restricted from receiving PHI information pertaining to a patient that is a minor, a Sun Valley Eye Care HIPAA F Form must be filled out along with a copy of the legal documentation to support the restriction to the records. Sun Valley Eye Care's HIPAA Form F and the legal documentation must be sent to Sun Valley Eye Care's HIPAA Compliance Officer. If you need to complete this form, please have the manager assist you with this request.

If there is no restriction to access (see paragraph above), please initial: *_____

I acknowledge that I have read and/or received a copy of the Sun Valley Eye Care's Notice of Privacy Practices and Conditions of Service**:** **Yes** Initials: *_____

*_____ *_____

Signature of Patient/Parent or Personal Representative Date Signed

*_____ *_____

Print Name of Patient/Parent or Personal Representative Relationship to Patient

**SVEC will only use your email and text msg number for communications regarding your appointments, orders, and for reminders for when the patient is due for another exam. You can opt out of the reminders at any time by responding "STOP"