sun valley eye care

Patient Contact & PHI Information Form

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

1. _____ Text**? ☐ Y ☐ N ☐ Cell ☐ Work ☐ Home
2. _____ Text**? ☐ Y ☐ N ☐ Cell ☐ Work ☐ Home

Address:_____

City, State, Zip:_____

Email**:_____

Gender: ☐ F ☐ M ☐ Other: _____ Patient's Social Security #:_____

Occupation:_____ Employer:_____

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: _____

Name: _____ Relationship: _____

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

*Signature/Initials needed in order to proceed with appointment

**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"