sun valley eye care

Patient Contact & PHI Information Form

Patient's Name: _____ **Birthday:** _____

Primary Phone: _____ Text: ☐ Yes ☐ No Type: ☐ Home ☐ Cell ☐ Work

Secondary Phone:_____ Text: ☐ Yes ☐ No Type: ☐ Home ☐ Cell ☐ Work

Address: _____

City, State, Zip: _____

Email: _____

Gender: ☐ Male ☐ Female ☐ Other

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: _____

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

*This must be completed in order to proceed with your appointment

**This authorization remains in effect until we receive written notice of change.