



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.