

**Patient Contact & PHI Information Form**

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the two best ways to contact you (List numbers in order of preference).

1.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   □ Home □ Cell    □ Work

2.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Home □ Cell    □ Work

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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, 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

Patient Contact & PHI Information                 12/14