Vision Square Eye Care 2019

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NOTICE OF PRIVACY PRACTICES AND DISCLOSURE OF PHI

A federal regulations known as the "HIPAA Privacy Rule" requires that we provide you a detailed notice in writing of privacy practices. This notice is available to all patients who ask to read it. In this notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient or where there is a reasonable basis the information can be used to identify a patient. This information is called "protected health information" or "PHI". Below you can request how Vision Square Eye Care communicates information to you. You may also request that only certain individuals be given information about your health, treatment or other personal information. ***Please fill out the questionnaire below.

PLEASE CONTACT ME IN THE FOLLOWING MANNER: Please circle your preferences

PATIENT NAME: ________________________________ **BIRTHDATE:** __________________________________

HOME PHONE: _________________________________ **CELL PHONE:** _________________________________

Leave detailed message on VOICE MAIL **Y N** ***Leave detailed message on VOICE MAIL*** **Y N**

Leave detailed message with a PERSON **Y N** ***Leave detailed message with a PERSON*** **Y N**

Name of Individual: ________________________________ **Name of Individual:** ________________________________

• A call back message stating the office called, a contact name and telephone number will be left at the numbers that you have answered NO.

WORK PHONE: __________________________________ ***Leave detailed message on PERSONAL VOICE MAIL*** **Y N**

- **Messages will not be left with a person at your work telephone unless you specifically indicate the name of the individual in the following space:** ____
- **ALL correspondence mailed will be in a sealed envelope addressed only to you, the two (2) exceptions are post cards to notify you that you have an appointment or that products are ready for you.**

I authorize Vision Square Optometrists and/or staff to discuss my PHI with the following individuals:

Name ____ **Relationship** ______________________ **Phone** __________________________

Name ____ **Relationship** ______________________ **Phone** __________________________

Name ____ **Relationship** ______________________ **Phone** __________________________

I acknowledge that I have been given the opportunity to read Vision Square Eye Care Notice of Privacy Practices and understand that the above will remain in effect until revised by me.

Patient/Legal Representative Signature: ____ **Date:** ___________________________

Staff Member Witness: ____ **Date:** ___________________________