179 York Road, Warminster, PA
215-674-2020

PATIENT RECORD OF APPROVED DISCLOSURE

The HIPAA Privacy Act gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). The individual is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means (i.e. calling cell/work phone instead of home).

Name (Printed):______________________________ **Date:_____________**

Kindly mark [X] the methods for which you approve to be contacted. Please note that messages (voice/text/email) will be regarding appointments, recalls, follow-ups, orders and payments.

[ ] Home Phone: (______)__________-________________

[ ] Work Phone: (______)__________-_________________

[ ] Cell Phone: (______)__________-________________

[ ] Email: ______________@__________________

Information Disclosure:

Besides those individuals associated with your eye care treatment/operations/payment, to whom else do you permit access to your records at this office?

____

Name Relationship

____

Name Relationship

Signature:____