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 Nationwide Vision HIPAA F Form must be filled out along with a copy of the legal documentation to support the restriction to the records. Nationwide Vision's HIPAA Form F and the legal documentation must be sent to Nationwide Vision'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 Nationwide Vision'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