Patient Contact & PHI Restriction 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 treat of 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

Please *INITIAL* the one that applies:

Initial: _____ NO restriction to access

Initial: _____ Restricted **Access**

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 Form F** 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 **FORM F**, please have the manager assist you with this request.

By signing below, I acknowledge that I have read and/or received a copy of the Nationwide Vision's Notice of Privacy Practices and Conditions of Service.

_____ _____

Signature of Patient/Parent or Personal Representative Date Signed

_____ _____

Print Name of Patient/Parent or Personal Representative Relationship to Patient