

# 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 & Nationwide Optometry 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 & Nationwide Optometry'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 & Nationwide Optometry'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