EST. 1961

PEARLE VISION

PHI Disclosure / HIPAA Notice / Email Consent

1) Personal Health Information (PHI) Disclosure

This form is used to identify the family members or other persons to whom we are authorized to disclose protected health information (PHI) about you or notify regarding your care. This form is effective for the duration of your care or until you provide further written notice.

Patient Name	**Date of Birth** (dd/mm/yyyy)

Instructions: Please list the person(s) to whom PHI about you may be disclosed.

Name	**Relationship to Patient**	**Telephone**

I attest that PHI related to my care and treatment may be disclosed to the person(s) identified above.

Signature	**Date**

If this form is being signed by a Patient's Authorized Representative on behalf of the Patient, complete the following:

Authorized Representative's Name ______________________________

Relationship to Patient and Reason for Signing ______________________________

2) Acknowledgement of HIPAA Notice of Privacy Practices (NPP)

I hereby acknowledge that I have read and/or received a copy (if requested) of this practice's NPP. I understand that if I have questions or complaints regarding my privacy rights that I may contact the office listed on the NPP. I further understand that the practice will offer me updates to the NPP should it be amended, modified, or changed in any way.

Signature	**Date**

3) Acknowledgement of Patient Email Consent

I acknowledge that I fully understand the practice's Patient Email Consent policy. I understand the risks associated with email communication about PHI and/or PFI between myself and the practice, and I consent to the conditions and instructions outlined, as well as any other instructions that the practice may impose to communicate with me by email.

Signature	**Date**
Email address	