HIPAA Privacy Form

Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's billing account and medical conditions to the patient or legal guardian.

If you would like to add additional contacts (other than the patient or legal guardian) that Slusher Eye Center is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like Slusher Eye Center to list as your Emergency Contact in the event an emergency situation was to take place at our office.

Contact Name	Relationship to Patient	Contact Phone Number
☐ **Billing Account Information**	☐ **Medical Condition Information**	☐ **Emergency Contact**

Contact Name	Relationship to Patient	Contact Phone Number
☐ **Billing Account Information**	☐ **Medical Condition Information**	☐ **Emergency Contact**

Preferred Method of Communication

My Preferred method of communication regarding my medical condition is indicated below (check one):

Write the number below:
(_____) _____

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Mailed Letter ☐ Guardian

If the above method of communication is by phone, please check the appropriate box below (check one):

☐ Leave a message with detailed information
☐ Leave a message with a call-back number only

Please note that you are responsible for any charges incurred in receiving our communication. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be called at all.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

_____
Patient Name (Please Print)

_____ _____
Signature of Patient, Parent, or Legal Guardian Date