Sun Eye Care, P.A.

CONSENT & DIRECTION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

In compliance with the HIPAA (Health Insurance Portability and Accountability Act) and to help protect your financial and health information, we ask that you complete this form. You may change your answers to this form at any time. We will keep a digital copy on file in your chart. We will endeavor to follow your wishes except when required by law as is described in the Notice of Privacy Protection statement which you have read and signed.

With regard to release of your health information, please read through the lists below and check the box that reflects your wishes.

During Examination

◯ Yes ◯ No You (Sun Eye Care, PA) may speak with any and all persons accompanying me during my examination directly and/or allow them to hear all information or discussions indirectly. I understand that if I don't want that person privy to the conversation, I must ask that person to leave the exam room.

◯ Yes ◯ No There are certain persons with whom I prefer you do not speak regarding my medical information while I am examined:

Name: Relationship

_____

_____

Telephone Contacts

◯ Yes ◯ No I consent to receiving any and all information regarding appointments, laboratory, radiology and other testing results as well as financial information, including reminders for outstanding bills on my home telephone line and/or personal cellular phone.

◯ Yes ◯ No Please restrict information as follows:

_____

_____

◯ Yes ◯ No You may leave voice mail messages or messages on my answering machine with regard to appointments, laboratory, radiology and other testing results as well as financial information.

If no, please list restrictions below:

_____

How may we leave the above information for you then?

_____

_____

◯ Yes ◯ No You may speak with or leave messages for me with any and all family members or significant others whether calling me as explained above or when or if they call with specific questions about my care.

◯ Yes ◯ No Except for in the event of an emergency, please restrict the information you leave as follows and/or do not speak with the following people:

_____

_____

Electronic Media

◯ Yes ◯ No You may contact me by various methods including e-mail, text messages or other internet or networking contact information that I leave with you and you may forward any information described above. Note that PHI will not be released into what is felt by us (Sun Eye Care, PA) to be a "non-secure" mode of transmission.

◯ Yes ◯ No Please restrict information or mode or media transmission as follows:

_____

_____

Other Restrictions

◯ Yes ◯ No I request restrictions on release of PHI as noted below:

_____

_____

_____

_____ _____

(Patient Signature) (Date)