HIPAA PATIENT NOTICE

It is our policy not to release confidential and/or unauthorized information on a home telephone, answering machine, work telephone, voice mail, or cell phone. When returning phone calls, we will not leave a detailed message on an answering machine if the identifying name or telephone number is not stated in the recorded message. We will not leave information with an unauthorized person who may answer the telephone. If you would like information released to someone other than yourself, please complete the following:

I authorize McElhinney Eye Care, PA, to leave detailed medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever the information changes.

Home telephone	☐ yes	☐ no
Answering machine	☐ yes	☐ no
Work telephone	☐ yes	☐ no
Cell phone	☐ yes	☐ no
Voice mail	☐ yes	☐ no

I hereby authorize McElhinney Eye Care, PA, to disclose appointment times, treatment, and test results (protected health care information) to the following people:

Name_____Relation_____ Phone #_____

Address_____

Name_____Relation_____ Phone#_____

Address_____

Name_____Relation_____ Phone#_____

Address_____

Name_____Relation_____ Phone#_____

Address_____

_____

Signature Patient/Guardian Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEGEMENT FORM

I, _____, have received a copy of the Notice of Privacy Practices.

Patient's Name