GENEVA EYE CLINIC

PATIENT HIPAA FORM

Patient Name _____

It may be necessary for the office to leave a message for you regarding medical information such as test results, prescriptions, billing or account information or other health care issues.

Can we leave a message on your:

Home Phone	☐ Yes	☐ No	Phone Number _____
Work Phone	☐ Yes	☐ No	Phone Number _____
Cell Phone	☐ Yes	☐ No	Phone Number _____

Please list every family member or friend who is authorized to speak with us about your health care issues. This includes spouses, children, or parents. Remember that if anyone calls us with a question, we will not be able to speak with them unless they are listed here.

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

This will remain in effect until it is revoked in writing.

Emergency Contact

_____	_____	_____
Name	Relationship	Phone Number

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of the Geneva Eye Clinic's Notice of Privacy Practices.

Patient Signature_____ Date_____

If not the patient, state your name and relationship. (If POA or guardian, please bring a copy for our records.)