VISION PLUS EYECARE
94 CHURCH AVE
RAINSVILLE, AL 35986
256-638-6386

Due to the HIPAA Compliance Privacy Laws of the Federal Government, it is mandatory that we ask you to review and answer the following questions listed below.

Name:_____ DOB: _____

(1) May we leave a message/detailed medical information on your voicemail at either of these phone numbers?

___ Yes ___ NO Home Phone:_____

___ Yes ___ NO Cell Phone:_____

(2) May we contact you at your employment? ___ Yes ___ No
If so, may we leave a message? ___Yes ___ No

If yes: Work Phone:_____ Extension:_____

(3) Do you have any particular person or family member that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing).

___ Yes ___No If yes, please provide:

Name:_____ Relationship:_____

Phone Number:_____ Alternate Number:_____

Name:_____ Relationship:_____

Phone Number:_____ Alternate Number:_____

I hereby authorize Vision Plus Eyecare to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the above information and provide my consent regarding any and all the issues as stated.

I understand that a copy of the Notice of HIPAA Privacy Policy will be provided to me upon request.

Patient Signature:_____Date:_____