HILLSBORO EYE CLINIC, P.C.

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# PATIENT COMMUNICATION/WRITTEN ACKNOWLEDGEMENT

**A. Family and Friends.** It is the office policy of Hillsboro Eye Clinic not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____ ☐ Yes ☐ No

Parent: _____ ☐ Yes ☐ No

Other: _____ ☐ Yes ☐ No

**B. Alternative Communications.** You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

**I hereby acknowledge receipt of Hillsboro Eye Clinic's Notice of Privacy Practices.**

Name (please print): _____

Signature: _____

DOB: _____ Date: _____

**I am a parent/legal guardian of** _____ **[patient name].**
**I hereby acknowledge receipt of Hillsboro Eye Clinic's Notice of Privacy Practices with respect to the patient.**

Patient DOB: _____ Relationship to Patient: ☐ Parent ☐ Legal Guardian

Name (please print): _____

Signature: _____

Date: _____