HIPAA PATIENT COMMUNICATION FORM

Family and Friends: It is office policy of *SNYDER EYE GROUP* not to release confidential medical information regarding your treatment to family members or friends except for;

1) parent /legal guardian
2) other persons authorized by the patient
3) as we may reasonably infer from the circumstances (for example, if you bring a family member into the exam room, we will assume, unless you object, that this person is entitled to receive information regarding your treatment
4) in emergency situations, or
5) other as otherwise permitted by 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, friend(s) or caretakers/baby-sitters, please indicate that below, so that we may best serve you. By signing below, you authorize that following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this IN WRITING to our staff.

Spouse _____ ☐ **Yes** ☐ **No**

Parent _____ ☐ **Yes** ☐ **No**

Other (specify relationship) _____ ☐ **Yes** ☐ **No**

May we leave a message on your home answering machine? ☐ **Yes** ☐ **No**

Phone Number ( ) _____ -_____

May we leave a message at your work? ☐ **Yes** ☐ **No**

Work Number ( ) _____ -_____

Patient/Parent/Guardian Signature _____ Date _____

Print Name _____

Signature below is only acknowledgement that you have received the HIPAA Notice of Privacy Practices

Signature _____ Date _____

Print Name _____