Patient Contact & Authorization for Disclosure of Protected Health Information

Patient Information:

Name: _____ ID Number: _____ Date of Birth: _____

Address: _____ Telephone: _____ Home ☐ Cell ☐

Policy Holder Information:

Name: _____ ID Number: _____ Date of Birth: _____

Address: _____ Telephone: _____ Home ☐ Cell ☐ Work ☐

I authorize the following person(s) to receive Private Health Information (PHI) pertaining to my treat of care other than myself or any Physician involved in my care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Information to be disclosed:

_____ Benefit, Policy and Procedure Information

_____ Claim/Payment Information

_____ Exam Chart – Provider Information

Purpose of Disclosure:

_____ Provide Information to family member or friend

_____ Required for legal matter

_____ Other

Restriction of Private Health Information – Extremely Important Information

Please *INITIAL* the one that applies. Initial: _____ **NO** restriction to access Initial: _____ **Restricted Access**

If there is someone, such as a parent, that is restricted from receiving PHI information pertaining to a patient that is a minor, a Nationwide Vision/ Nationwide Vision Optometry HIPAA Form F must be filled out, along with a copy of the legal documentation to support the restriction to the records.

My protected health information is information about me, including information such as my name and address/or medical information. The information was used or created when I received vision care or when payment was received for my vision care. The information may include my past, present, or future vision health care or condition. I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that my authorizing the use and disclosure of my "protected health information" is not a condition of my eligibility for benefits or payments of my claims.

Right to Revoke: This authorization may be revoked at any time. Contact Nationwide Vision at 480-835-4472 for further instructions. Revocation of this authorization will not affect any action taken before Nationwide Vision receives the notice of the revocation.

_____ _____

PRINTED Name of Patient/Parent Date Signed

_____ _____

Signature of Patient/Parent Relationship to Patient

If this authorization is signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative's Name: (please print) _____

Personal Representative's Signature: _____

Description of Personal Representative's Authority: _____