the eye clinic
surgicenter | 2475 Village Lane. Billings, MT. 59102 T: (406) 252.6608 F: (406)252.6600

PATIENT COMMUNICATION REQUEST / ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS

To respect your privacy, please tell us how you would like us to communicate with you regarding your eye care results, appointments, and billing concerns.

If you are not available to take our call, do you authorize us to leave a message on the provided phone numbers?
Home [ ] Yes [ ] No Work [ ] Yes [ ] No Cell [ ] Yes [ ] No

Can we text you for appointment reminders / statement announcements [ ] Yes [ ] No
Can we email you for appointment reminders / statement announcements [ ] Yes [ ] No

Release of information to others:

I authorize the release of my protected health information to the individuals listed below according to the options listed. I understand that my options for release are: ALL RECORDS refers to all appointments, billing, and diagnosis and treatment plans, MEDICAL (MED) refers to diagnosis and treatment plans only BILLING (BIL) refers to transaction data for payment only, APPOINTMENTS (APPT) refers to information regarding scheduled/scheduling appointments.

I understand that if I do not authorize an indivIdual they will not be able to talk to anyone at The Eye Clinic Surgicenter on my behalf.

NAME	PHONE # & RELATIONSHIP	TYPE OF AUTHORIZATION
		[ ] ALL [ ] MED [ ] BIL [ ] APPT
		[ ] ALL [ ] MED [ ] BIL [ ] APPT
		[ ] ALL [ ] MED [ ] BIL [ ] APPT
		[ ] ALL [ ] MED [ ] BIL [ ] APPT
		[ ] ALL [ ] MED [ ] BIL [ ] APPT
		[ ] ALL [ ] MED [ ] BIL [ ] APPT

This release is for verbal releases only; no medical records will be mailed or faxed without written authorization from the patient or personal representative. I understand that I have the right to revoke this authorization at any time by sending a written notification to The Eye Clinic Surgicenter.

I acknowledge that I have been given a copy and understand The Eye Clinic Surgicenter's HIPAA Notice of Privacy Practices dated 8/15/2013.

_____
Signature of Patient or Personal Representative Date

_____
Print Patient Name