Cherokee Eye Group Inc.
Dawson Eye Group

Patient Health Information Disclosure Preferences

1. **Telephone** Communication Preference

Location	May we contact you here?		May we leave a message?	
HOME	Yes	No	Yes	No
WORK	Yes	No	Yes	No
CELL	Yes	No	Yes	No
OTHER	Yes	No	Yes	No

2. To whom may we communicate your private healthcare information? (Other than insurance companies and healthcare providers involved in your care). Please initial beside each approved option.

Individual	Name of Individual	Telephone #	Patient Initial
Spouse			
Caretaker			
Child			
Parent			
Other			

I acknowledge that I have been given the opportunity to request restrictions on use and/ or disclosure of my protected health information. I also acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Patient Name: ______________________________

Patient Signature: ______________________________ Date: ____________________

Contact Person:

Our contact person for all questions, request or further information related to the privacy of your health information is: KIM ARP

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this notice are available upon request in our reception area.
Notice Revised and Effective: September 23, 2013

ACKNOWLEDGEMENT OF RECEIPT

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND REVIEW THE NOTICE OF PRIVACY PRACTICES FOR CHEROKEE EYE GROUP, INC AND DAWSON EYE GROUP.

Patient Name: ______________________________ Signature: ______________________________

Date: ______________________________