Cherokee Eye Group Inc.
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: _____

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization: I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Cherokee Eye Group, Inc. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose: The photographic/video images, and/or testimonial will be used for: *Social Media and/ Advertising.*

Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires in 99 years from date signed.

Please Check One: ☐ **I Agree** ☐ **I Decline**

Patient Name:_____

Signature:_____

Date:_____

If Patient is a Minor:

Parent/Legal Gaurdian: _____

Signature:_____

Date: _____

If Personal Representative:

Name:_____

Date:_____

Relationship to the Patient:_____

Contact Person: Our contact person for all questions, request or further information related to the privacy of your health information is: Jennifer Borum

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: November 17, 2017