Heimer Eye Care Associates, P.C.

PRIVACY INFORMATION **Date: _____**

NAME _____ **DOB _____**

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

How can we communicate APPOINTMENT INFORMATION?

Home phone?	☐ **Yes**	☐ **No**
Cell phone?	☐ **Yes**	☐ **No**
Work phone?	☐ **Yes**	☐ **No**
With a specific person?	☐ **Yes**	☐ **No**
U.S. mail?	☐ **Yes**	☐ **No**
Email?	☐ **Yes**	☐ **No**

How can we communicate MEDICAL INFORMATION?

Home phone?	☐ **Yes**	☐ **No**
Cell phone?	☐ **Yes**	☐ **No**
Work phone?	☐ **Yes**	☐ **No**
With a specific person?	☐ **Yes**	☐ **No**
U.S. mail?	☐ **Yes**	☐ **No**
Email?	☐ **Yes**	☐ **No**

Please provide the name and relationship of the specific person(s) with whom we may share patient information (medical, billing and appointments) about you. This information will expire only when requested by the patient.

Name:	**Relationship:**	**Phone:**	**Cell Phone:**