

Vision Square Eye Care

Dr. Christopher J. Moshoures Dr. Kathy DesLauriers Dr. Elizabeth J Cooke

NOTICE OF PRIVACY PRACTICES AND DISCLOSURE OF PHI

A federal regulation known as the "HIPPA Privacy Rule" requires that we provide you a detailed notice in writing of privacy practices. This notice is available to all patients who ask to read it. In this notice, we describe the ways that we may use and disclose health information about our patients. The HIPPA Privacy Rule requires that we protect the privacy of health information that identifies a patient or where there is a reasonable basis the information can be used to identify a patient. This information is called "protected health information" or "PHI". You may request that only certain individuals (usually close family or friends) be given information about your health, treatment or other personal information. You can also request ho Vision Square Eye Care communicates information to you.

**We need to have a way to contact you or leave a message during the day time hours.
Please complete the short questionnaire below.**

Please contact me in the following manner:

Home Phone # _____

It is ok to leave detailed information on voice mail? Y N

Is it ok to leave detailed information with a person? Y N

If so, name of individuals. _____

Cell Phone # _____

Is it ok to leave detailed information on voice mail? Y N

Work Phone # _____

Is it ok to leave a detailed message on personal voice mail? Y N

***Messages will not be left with a person at work unless you have specifically indicated the name of the person in the following space: _____

If the above are answered **NO**, a message will be left only stating that our office called and a name and call back number will be left.

All correspondence mailed to you will be in a sealed envelope addresses only to you, the **two (2)** exceptions to this are a post card notify you that glasses are ready and a post card for appointment reminders.

I authorize Vision Square Eye Care doctor's and staff to discuss my PHI with the following individuals:

I acknowledge that I have been given the opportunity to read Vision Square Eye Cares Notice of Privacy Practices and understand that the above will remain in effect until revised by me.

Patient or Legal Representative (POA)

Date

Staff Member Witness

Date