HIPAA PATIENT CONSENT/HIPAA PRIVACY PRACTICES POLICY

See Sharp Eyewear/David M. Girardi, OD, LLC
824 Franklin Park Drive
East Syracuse, NY 13057
p. 315-446-1288
f. 315-446-2210

Patient Communication Consent

Patient Name: _____ Date of Birth: _____

Patient telephone numbers which we are allowed to call
Home: _____
Cellular: _____
Work/Other: _____

Please initial one and sign below:

_____ I authorize the office of See Sharp Eyewear/David M. Girardi, OD, LLC to speak with me or my alternate person in regards to appointments, health and account information, and/or orders ready for pick up via home, cellular, or work telephone, electronically, or by postal mail. **I authorize the office to leave a message with detailed information on any or all of my answering machines, voice mail, electronically, or with the contact person listed below.**

Name of person with whom messages may be left (or self if you do not wish to have messages left with another person or on a voice mail/answering machine): _____
Relationship: _____
Telephone of alternate person or allowed voice mail/answering machine: _____
Authorized email: _____
By providing an email address, I am granting you permission to link that address to my patient portal account.

_____ **I do not authorize any contact** from See Sharp Eyewear/David M. Girardi, OD, LLC office for any reason. I will take it upon myself to contact this office in regards to: appointments and billing/ordering inquiries.

* This record of consent is effective from date of patient signature until further notice. Any changes must be recorded on a new record of consent and will make any previous records of consent null and void.*

Patient Signature: _____ Date: _____

HIPAA PRIVACY NOTICE

By signing below I have been offered See Sharp Eyewear/David M. Girardi, OD, LLC notice of HIPAA privacy practices policy. I have had the choice to either receive a written HIPAA privacy practices policy, read the HIPAA privacy practices policy in office or I have declined to read the HIPAA privacy practices policy.

Patient Signature: _____ Date: _____