McCoy Vision
100A Providence Main Street
Huntsville, Al 35806
256-382-2700

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____DOB: _____

1. May we leave a message/detailed medical information on your voicemail at either of these phone numbers?

__YES __NO Home Phone: _____

__YES __NO Cell Phone: _____

2. May we contact you at your place of employment? ___Yes ___No
If so, may we leave a message? __Yes __No

If yes: Work Phone: _____ Extension: _____

3. Do you have any particular person or family member that you authorize to receive and discuss information regarding your personal health information (general information, surgical, and billing).

___Yes ___No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purpose? ___Yes ____No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize _____, to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the above information and provide my consent regarding any and all the issues as stated.

I have reviewed Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

**Patient Signature**: _____ **Date**: _____