SHARPER VISION
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913.787.6724

New Patient
HIPAA form

I have received the Notice of Privacy Practices from Sharper Vision, PA.

Patient Initials _____

I hereby allow Sharper Vision, PA to disclose the following protected health information:

Appointment Dates	YES	NO
Examination Finding	YES	NO
Test Results	YES	NO
Other Health Information	YES	NO

To the following people because they are directly involved with my health care or payment for my medical services (please check and write in names):

Self _____

Spouse _____

Family/Friend _____

Child _____

Other _____

In the following forms of communication:

Home Telephone	YES	NO
Work Telephone	YES	NO
Home Voice Message System	YES	NO
Work Voice Message System	YES	NO
Cellular Phone	YES	NO
E-mail	YES	NO

I authorize Sharper Vision, PA to send medical and/or surgical patient information to me by the e-mail address I have provided. Initials _____

I authorize Sharper Vision, PA to send a "Thank You" note to the friend/relative that referred me to this office. Initials _____

Patient Name _____

Patient/Guardian Signature _____