Chili Vision Group

3173 Chili Avenue, Suite 400

Rochester, NY 14624

HIPPA Privacy Notice

I _____, DOB:_____ am aware of the HIPPA Privacy Notice and a copy will be made available to me at my request.

___No, I do NOT wish to have my protected health information discussed with anyone other than myself.

___Yes, Dr. Pamela Brown, Dr. Melanie Shearer, Dr. Shruti Pandya and/or emploees of Chili Vision Group, have permission to discuss my eye care and/or medical conditions and care with the following designated person(s).*

*Friend, Family member, or someone other than your Optometrist(s)

Name_____ Relationship_____ Home and/or Cell Phone _____

Name_____ Relationship_____ Home and/or Cell Phone _____

Please circle YES or NO for each question below:

Leave APPOINTMENT reminder/information message on:

Home Phone: Yes No

Cell Phone: Yes No

Office Voice Mail: Yes No

Office Person other than you: Yes No

Leave Other Medical Information on:

Home Phone: Yes No

Cell Phone: Yes No

Office Voice Mail: Yes No

Office Person other than you: Yes No

Signature: _____

Date: _____