Ralph S. Viola, MD
1157 Fairport Road, Suite 201
Fairport, NY 14550
585.586.9900

HIPPA Privacy Act and Consent to Discuss Medical Information

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

_____ No, I do not wish to have my protected health information discussed with anyone other than myself. The information can continue to be shared among your other health care providers.

OR

_____ Yes, Dr. Viola and employees of Eyes on Rochester have my permission to discuss my medical care with the following designated friends or family members.

_____	_____	_____	_____
Name	Relationship	Home Phone	Cell Phone
_____	_____	_____	_____
Name	Relationship	Home Phone	Cell Phone

Please circle Yes or No for each question;

Leave **appointment** message on;

Home phone Yes No _____

Cell Phone Yes No _____

Office Voice Mail Yes No _____

Leave Medical Information on;

Home Phone Yes No

Cell Phone Yes No

Office Voice Mail Yes No

Signature_____ Date_____

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