ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Wheaton Eye Clinic Notice of Privacy Practices. Furthermore, I understand that my Wheaton Eye Clinic physicians and providers participate in the Epic Connect Program and that my patient data will be stored in a shared community electronic record. My clinical data may be shared with Northwestern Medicine, its affiliates and other healthcare providers who are associated with my medical care. The Wheaton Eye Clinic prohibits patient photography and/or video or audio recording on the premises.

A copy of our Privacy Practices is available at the front desk.

_____ _____

Signature of Patient (or Power of Attorney/Legal Representative) Date

_____ _____

Patient Name (Print) Patient Date of Birth

_____

Power of Attorney/Legal Representative (Print)

If person signing is a Power of Attorney/Legal Representative, describe relationship to the patient:

_____

_____

Wheaton Eye Clinic has my permission to leave information regarding my medical condition on my:

Home Answering Machine (_____) _____-_____

Cell Phone (_____) _____-_____

Work Voicemail (_____) _____-_____

Patient's email address* (_____) _____-_____

Guardian email address* (_____) _____-_____

Wheaton Eye Clinic has my permission to communicate my health information to the following individuals:

Name: _____Relation to patient: _____ Phone: _____

Name: _____Relation to patient: _____ Phone: _____

*To assure Wheaton Eye's compliance with government regulations, I understand Wheaton Eye Clinic may use either my or the guardian's email address to implement patient portal messaging.

www.wheatoneye.com