MY HEALTH INFORMATION CONSENTS AND ACKNOWLEDGEMENTS

I acknowledge that I have reviewed the Wheaton Eye Clinic Notice of Privacy Practices, and understand additional copies are available at the Wheaton Eye Clinic office where I will be receiving treatment.

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.

I agree that all telephone numbers and email addresses that I provide to Wheaton Eye Clinic may be used by Wheaton Eye Clinic or those acting on its behalf to communicate with me by phone call, (including cell phones), text, or any automated or prerecorded messages. If I do not want to receive a text message or phone call, then I can send an email to info@wheatoneye.com and ask to be removed from this list.

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

Wheaton Eye Clinic has my permission to communicate my health information to my Emergency Contact as listed within the Epic database.

I acknowledge that Wheaton Eye Clinic prohibits patient photography and/or video or audio recording on the premises.

I have read, understand, and agree to the My Health Information Consents and Acknowledgements form.

Print Patient Name Date of Birth

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

Printed Name of Power of Attorney/Legal Representative