WHEATON
EYE CLINIC

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 an electronic record owned by Northwestern Medicine. My clinical data may be available to Northwestern Medicine, its affiliates and other healthcare providers who are associated with my medical care.

I agree that all phone 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, voicemail, unencrypted email, unencrypted text, or any automated or prerecorded messages. I understand that any unencrypted communications may be intercepted by unauthorized users, and I accept the risk of using unencrypted communications. If I do not want to receive text messages, emails, phone calls, or voicemails I understand I can send an email to info@wheatoneye.com and ask to be removed from this list.

To ensure compliance with government regulations, I understand Wheaton Eye Clinic may use the email address I provide or the email address of my guardian to initiate patient portal access and messaging.

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

Wheaton Eye Clinic has permission to contact me and leave information about my medical condition at:

Cell Phone _____ Home Phone _____

Email Address _____

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

Name _____ Relationship to Patient _____ Phone _____

Name _____ Relationship to Patient _____ Phone _____

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

_____

Print Patient Name Date of Birth

_____

Signature of Patient / Parent / Guardian / Legal Representative Date

_____

Print Name of Parent / Guardian / Legal Representative