CASCADE EYE CARE

Privacy Practice and Communication Consent

This combined consent form outlines how our practice communicates with you, how we protect your health information, and your choices regarding who may receive your Protected Health Information (PHI). By signing below, you acknowledge and consent to the terms described in this document.

1. Communication Consent and Authorization for Messages

We strive to provide excellent care and timely updates. By signing this form, you authorize the practice to contact you regarding appointments, scheduling updates, clinical notifications, and other relevant information through the following methods: - **Email, SMS (Text Messages), and Phone Calls.** By providing the information, you also agree to receive messages for appointments, prescription renewals, lab results, and other Protected Health Information* (PHI) through that means of communication.

Home Phone: _____

Cell Phone/Text: _____

Email: _____

Details of Consent

- By providing your contact information, you give permission for the practice to send reminders and notifications.
- **SMS Messages:** Message frequency may vary. Standard message and data rates may apply.
- **Opt-Out:** Reply **STOP** to any text message to discontinue SMS communications. For help, reply **HELP** or contact the office directly.
- **Privacy Information:** Our complete privacy policy is available on our website.

2. Authorization to Share PHI With Others

You may authorize us to share your PHI with designated individuals. This authorization remains valid until revoked in writing.

- **Spouse or Partner:** ☐ Yes ☐ No

Name: Date of Birth: Phone:

- **Other Authorized Individuals:**

CASCADE EYE CARE

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

You may change these permissions at any time by submitting a written notice. Once PHI is shared with the authorized parties, it may no longer be protected under federal or state privacy laws.

3. Patient Portal Enrollment

You are automatically enrolled in our secure online Patient Portal, which offers 24/7 access to your medical information. Check the box if you wish to **opt out** of the Patient Portal. ☐ I choose to opt out of the Patient Portal.

4. Patient Acknowledgment & Signature

By signing below, you acknowledge the following: - You understand the communication methods described above. - You consent to receiving communications from the practice. - You acknowledge receipt or availability of the Notice of Privacy Practices. - You understand your rights regarding PHI disclosure and authorization.

Patient Name (Print):_____ Date of Birth:_____

Patient Signature:_____ Date:_____

Parent/Guardian Name:_____ Relationship to Patient:_____

I understand that I can change any of the foregoing agreements at any time by giving written notice to Cascade Eye Care. My PHI may be further disclosed by such a recipient for the purposes referenced above, and state and federal laws may no longer protect my PHI because I have authorized the release of such information. I also understand that if any harm results after the authorized release to such person(s), Cascade Eye Care will not be held liable for damages.