RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT

I, _____ HAVE REVIEWED A COPY OF The Center for Eye Care & Opticalôs notice of Privacy Practices.

EXPRESS AUTHORIZATION FOR THE DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. The Center for Eye Care & Optical may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit The Center for Eye Care & Optical to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

_____ _____
(relationship to me)

_____ _____
(relationship to me)

_____ _____
(relationship to me)\

I expressly permit The Center for Eye Care & Optical to disclose my protected health information for the purposes of appointment/test/procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine: Tel.# _____

Office voicemail: Tel.# _____

Other (specify): _____ Tel.# _____

_____ _____
Signature of Patient Date
Personal Representative
Parent/Guardian