EYE CARE & SURGERY, P.C.

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Patient Name

Acknowledgement OF RECEIPT OF PRIVACY NOTICE/AUTHORIZATION FOR RELEASING INFORMATION

I have been presented with a copy of this practice's **NOTICE OF PRIVACY POLICIES**, detailing how my information may be used and disclosed as permitted under federal and state law.

I hereby authorize Eye Care & Surgery to disclose any and all information necessary in the customary and normal procedures of the office as listed in the privacy notice. I realize I have the right to restrict who may have access to this information and may do so by submitting any restrictions in writing.

____ Date ______________
Signature of Patient or Parent/Guardian (if Patient is a minor)

____ Date ______________
Authority (if not signed by Patient)

REQUEST/CONSENT TO DISCLOSE HEALTH INFORMATION

I hereby request that health information be discussed with and disclosed to the family members, relatives, or friends listed below. The individuals identified below are involved in my care and/or payment for my care, and I agree that the provider listed above may share such information as the provider may deem relevant to such individual's involvement, including appointment times, required care and diagnoses. I understand that I have the right to revoke this request/consent by delivering written notice to the provider.

Please list individuals: ____

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____ Date ______________
Signature of Patient or Parent/Guardian (if Patient is a minor)

____ Date ______________
Authority (if not signed by Patient)