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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By my signature below, I acknowledge that I have received The Eye Institute's Notice of Privacy Practices.

**Name** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

This acknowledgement page should be retained in the patient's record. If acknowledgement could not be obtained from patient, the reasons must be documented below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PROTECTED HEALTH INFORMATION RELEASE FORM**

In compliance with HIPAA regulations, and in order to facilitate requests for your protected health information, please complete the lower portion of this form.

I authorize the person(s) listed below to have access to any of my protected health information, including HIV, drug and alcohol abuse and psychiatric records. The Eye Institute is permitted to share with them test results and information disclosed during my office visits. For copies of medical records, I understand that I will need to sign a separate authorization. Please list below those individuals that you wish to receive your protected health information:

**Full Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Full Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

In addition to those individuals listed above, I request that you may also notify me of test results, appointment confirmations, and other information related to my health in the following manner:

- Leaving messages on answering machine at \_\_\_\_\_.
- Leaving messages on my work voicemail at \_\_\_\_\_.
- Leaving messages on my pager at \_\_\_\_\_.
- Leaving messages on my cell phone at \_\_\_\_\_.
- Other forms of communication \_\_\_\_\_.

I understand that I will update The Eye Institute with any changes in the above listed contact numbers. I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient Signature** \_\_\_\_\_

**Witness Name** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_