The Eye Associates

Patient Acknowledgment of Receipt of Notice of Privacy Practices & Designation of Authorized Persons

Patient Acknowledgment

By signing below, I acknowledge that I have received or been offered a copy of **The Eye Associates**' Notice of Privacy Practices. I understand that this Notice describes how my health information may be used and disclosed in accordance with HIPAA and the HITECH Act and details my rights regarding my health information.

Patient Information

Patient Name: _____ **Date of Birth:** _____
Phone Number: _____ **Email Address (optional):** _____

Designation of Authorized Persons

In accordance with HIPAA, you may designate individuals who are authorized to receive your Protected Health Information (PHI) on your behalf. This includes appointment details, test results, billing information, and other health information.

I authorize **The Eye Associates** to release my PHI to the following individuals:

1. Name: _____
Relationship to Patient: _____
Phone Number: _____

2. Name: _____
Relationship to Patient: _____
Phone Number: _____

3. Name: _____
Relationship to Patient: _____
Phone Number: _____

☐ **I do not wish to authorize anyone at this time.**

Authorization Terms

- This authorization will remain in effect until I revoke it in writing.
- I understand that this authorization is voluntary and that I may restrict or revoke this consent at any time.
- Revocation will not apply to information that has already been released under this authorization.

Patient Signature

Patient Signature: _____ **Date:** _____

If signed by legal representative, print name and relationship to patient:

Name: _____ **Relationship:** _____