HIPAA: Notice of Privacy Practices

ACKNOWLEDGEMENT of RECEIPT

I acknowledge that I have been offered or have received a copy of Island Eyecare's "Notice of Privacy Practices".

AUTHORIZATION to DISCUSS MEDICAL INFORMATION

I authorize Island Eyecare doctors and/or staff to release or discuss my private medical information to the following:

__ No One

__ Spouse (name and date of birth) _____

__ Other (name and relationship) _____

Patient Name Printed:

Signature: _____

Effective Date: