RetinaCare CONSULTANTS

13 Sunset Drive
Latham, NY 12110
Tel (518) 218-1234

Acknowledgement of Receipt of Privacy Policy

I understand that RetinaCare Consultants Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills, or in the performance of the health care operations of RetinaCare Consultants. Our Notice of Privacy Practices explains our use and disclosure of your Protected Health Information. This notice is posted in the office reception area. I acknowledge that I can receive a copy of this notice.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that RetinaCare Consultants has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer.

Disclosures

Do we have permission to:

Leave Appointment Information:		**Leave Medical Information:**	
On Home Phone?	[ ]	On Home Phone?	[ ]
On Cell Phone?	[ ]	On Cell Phone?	[ ]
On Office Voicemail?	[ ]	On Office Voicemail?	[ ]
With Another Person?	[ ]	With Another Person?	[ ]
Via Mail?	[ ]	Via Mail?	[ ]

Person(s) Authorized to Communicate With:

Name _____ Address _____ Relationship _____

Phone (H) _____ (W) _____ (C) _____

Name _____ Address _____ Relationship _____

Phone (H) _____ (W) _____ (C) _____

Please understand that we will not be able to release any information about your medical condition to anyone not authorized by you. It is your responsibility to change and/or update this information as necessary.

Patient Name (Print) _____ Date of Birth _____

Name of Legal Guardian (Print) _____ Relationship to Patient _____

Signature of Patient or Legal Guardian _____ Date _____