ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Notice to Patient:

Mid-America Eye Center is required to provide you a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment if you wish.

I acknowledge that I received a copy of Mid-America Eye Center's Notice of Privacy Practices.

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Please print your name here

______________________________ ______________________
Signature *Date*

AUTHORIZATION FOR RELEASE OF INFORMATION TO A RELATIVE / FAMILY MEMBER

I hereby authorize the release of the following medical information (check one):

- ☐ All information
- ☐ Other. Please specify: ______________________________
- ☐ I do **not** wish to release any personal, medical information to a relative / family member.

To:

Relation Name	Relation to Patient
Home Telephone Number	Work or Alternate Telephone Number
Patient Name (Printed)	Patient Date of Birth
Patient Signature	Doctor

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of our receipt of our Notice of Privacy Practices from this patient, but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency it was not possible to obtain an acknowledgment.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

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______________________________ ______________________
Employee Signature *Date*

Updated 8/8/13