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Doctors you know... Doctors you trust

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

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

Patient signature: _____ **Date:** _____

Patient name (print): _____

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.

If you have any questions regarding our HIPAA compliance, please refer to our HIPAA manual in the reception area.

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. Pittsburgh 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 want 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 Pittsburgh 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 Signature

Date

Patient Name (print)

Witness Name

Date