Family Eyecare of Scottsdale

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HIPAA/PRIVACY ACKNOWLEDGEMENT

In complying with the Health Insurance Portability and Accountability Act, HIPAA, we want to make sure that we guard all of your health care information according to your wishes.

I authorize Family Eyecare of Scottsdale to release my medical/vision care information to the following parties:

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____Phone# _____

Name _____ Relationship _____ Phone# _____

You must inform us, **in writing**, of any changes in your directives. This will be kept in your medical record along with acknowledgement of receipt of our Notice of Privacy Practices.

Signature: _____ Date: _____

PATIENT RECORD/INFORMATION RELEASE FOR MEDICAL OFFICES

I authorize the release of any information necessary to provide health care, including medical records, charts, test results, notes and other records. I request that a copy of these records be faxed to Family Eyecare of Scottsdale.

In the event the patient is a minor or individual under guardianship, power of attorney or conservatorship, the person signing must be duly authorized to serve in such capacity and sign below for the patient:

Signature: _____ Relationship: _____

Patient Name: _____ DOB: _____