Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Ocala Eye's **Notice of Privacy Polices**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and if I have a request for restriction(s) concerning the use of my personal medical information, I will submit my request in writing to the Privacy Officer of Ocala Eye.

Print Name:____

Signed: ______________________________ Date:_______________

If not signed by the patient, please indicate your relationship to the patient (e.g. spouse)

Relationship: ______________________________
Witnessed by: ______________________________

IF PATIENT REFUSES TO SIGN, DOCUMENT YOUR ATTEMPT TO OBTAIN A SIGNATURE.

[ ] Patient refused to sign this Acknowledgement.
[ ] Other____

Date:________________ Time:________ Employee Name:___________________________

MEDICAL/FINANCIAL RELEASE OF INFORMATION AUTHORIZATION

I, ____, hereby authorize
Patient Name

Ocala Eye, P.A. to release information about my medical and financial records if requested by:

____
Name Relationship Daytime Phone Number

____
Name Relationship Daytime Phone Number

______________________________________ ____________________
Signature of Patient or Legal Guardian Date