ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I acknowledge that I have received the Notice of Privacy Policies for Pocono Eye Associates

_____________________________________ _______________________________
Print Patient Name Date of Birth

_____________________________________ ________________________________
Patient/Legal Representative Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, children or others to call and request medical or billing information. Under the requirements of HIPAA we are not permitted to release information to anyone without the patient's consent. **If you wish to have your medical and billing information released to family members, you must sign below**. Signing below will only give information to the family members identified below.

I authorize Pocono Eye Associates to release my medical, billing and appointment information to the following individual(s):

1. ____ Relation to Patient: ____________________________
2. ____ Relation to Patient: ____________________________
3. ____ Relation to Patient: ____________________________

Patient Information:

1. I understand I have the right to revoke this authorization at any time by written request to Pocono Eye Associates
2. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient

_____________________________________ _______________________________
Patient/Legal Representative Signature Date