



ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have received a copy of the Privacy Notice.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative

North Columbus Eye Center may share my health information with listed person(s) on this authorization form.

Print name: _____ phone: _____

Relationship: _____

Print name: _____ phone: _____

Relationship: _____

ALL MEDICAL INFORMATION

LISTED INFORMATION _____

I wish to be communicated with in the following manner.

(please check all that apply)

Home phone _____

Can leave message with detailed information

Leave message with call back number only

Cell phone _____

Work Phone _____

Can leave message with detailed infor.

Leave message with call back number only

Written Communication

Can mail to home address

Can mail to office/work address

Can fax to this number _____

Other _____
