Vision Care Center of Northeast Arkansas

Acknowledgement of Receipt

Notice of Privacy Practices

Your signature acknowledges that you have received a copy of the Notice of Privacy Practices.

Patient Name_____ Date of Birth_____

Signature of Patient_____

Patient Representative (if applicable) _____

Relationship of Representative_____

Date Signed_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This authorization will allow Entity to disclose protected health information to the specific person, company, or agency listed below.

I, _____
NAME OF PATIENT

Hereby Authorize_____
NAME OF ENTITY

To Release_____
INFORMATION TO BE DISCLOSED

To_____

Address_____ Phone_____ Fax_____

NAME OF PERSON OR COMPANY AUTHORIZED TO MAKE USE OF DISCLOSURE

IMPORTANT INFORMATION TO THE PATIENT MAKING THIS AUTHORIZATION

- You have the right to withdraw (revoke) this authorization at anytime except to the extent that the action has been taken in reliance on the authorization.
- To withdraw or revoke this authorization, please provide your request in writing to the Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re disclosure by the recipient and may no longer be protected by the federal privacy law.
- You have the right to inspect or copy the information that is disclosed in accordance with this authorization.
- You have the right to receive a copy of this signed authorization.
- You have the right to refuse to sign this authorization and Entity will not condition the provision of treatment on your authorization to disclose this information.

Signature_____Date_____
Signature ofAuthorizedRepresentative_____
Relationship_____