

Acknowledge Receipt of Notice of Privacy Policies

Release of PHI to Specified Parties

My signature below acknowledges the receipt of Shepherd Eye Center's Notice of Privacy Policies.

Signature _____

Date _____

Print Name _____

Social Security # _____

Do we have permission to release your protected health information to anyone involved in your care? YES NO

If "YES", list the **name(s)** of the person(s) who has permission for access to your protected health information. Please do not use general descriptions such as "**family**", or "**friend**". We need name, relationship and telephone number. Also, list information they have access to, for example, "entire medical records", "specific dates", "specific types of examination", etc.

Name _____
Telephone _____
Relationship _____
Information _____

Name _____
Telephone _____
Relationship _____
Information _____

Name _____
Telephone _____
Relationship _____
Information _____

Name _____
Telephone _____
Relationship _____
Information _____

I understand that my permission for the release of my protected health information to parties listed above will remain in effect indefinitely unless revoked in writing.

Patient Name (printed) _____

Patient Signature _____ Date _____

Patient representative signature if patient unable to sign. _____

Relationship _____ Date _____

DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY

Patient named below refused to sign an acknowledgement for the receipt of Shepherd Eye Center's Notice of Privacy Policies.

Patient Name: _____

Date: _____

Office Staff Signature: _____