Notice of Privacy Practices

Receipt of Notice of Privacy Practices/Written Acknowledgement Form I have received/read a copy of Pasadena Eye Associates Privacy Practices.

Signature _____ Date _____

PERMISSION TO RELEASE HEALTH INFORMATION

I wish to be contacted in the following manner (check all that apply)

☐ Home Telephone _____

Work Telephone _____

Written Correspondence

O.K. to mail to my home address

O.K. to fax to this number _____

To whom may we <u>not</u> talk to about your medical and billing information?

Name _____

Relationship _____

Other _____

Patient/Guardian Signature _____ Date _____