Odom's Eye Care

Acknowledge of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received Odom's Eye Care Notice of Privacy Practices:

Patient Name: _____ Patient Date of Birth: _____

Any physician, staff, employee or representative of Odom's Eye Care has my permission to **discuss** my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

_____	_____	_____
Name	Relationship	Phone Number (s)
_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)

Odom's Eye Care calls and sends recall notices for appointments via mail by post card or on occasion we may send an email or text message if we are unable to reach you by phone.

Please check if this is agreeable with you:
____ Post Card
____ Text to my cell phone
____ Email

Email _____ Phone _____

____ I wish to pay in **CASH** in full (out of pocket) for my treatment, and instruct **Odom's Eye Care** not to share information about my treatment with my health plan.

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke in writing to Odom's Eye Care or complete a new form at any time. This authorization will remain in effect until I change or Revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individuals.

Patient or Guardian's Signature _____Date _____