FLORIDA EYE
ASSOCIATES

ACKNOWLEDGMENT FORM

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by requesting it from the personnel at check-in.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations as described in our Notice. You consent to the use of your answering machine/voicemail by this office for brief messages regarding your medical care. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name

(Print) _____

(Sign) _____

(Date) _____

(Witness) _____

Release of Personal Health Information Issues regarding my medical care may be discussed with the following individuals:

Printed Name	Relationship
_____	_____
_____	_____
_____	_____