PATIENT AUTHORIZATION
FOR DISCUSSION OF HEALTHCARE AND/OR BILLING INFORMATION

Date: _____ Birth Date: _____

Patient Name: _____

Personal Representative (if necessary): _____
(Parent, Guardian, POA, etc.)

Allied Eye Physicians & Surgeons, Inc. has authorization to discuss my healthcare and/or billing information with the following persons:

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

This authorization will be affecting indefinitely, unless I revoke it. I understand I am allowed to alter this authorization at any time. I do not have to sign this authorization in order to receive treatment from Allied Eye Physicians & Surgeons, Inc. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule. I have the right to revoke this authorization in writing, except to the extent that Allied Eye Physicians & Surgeons, Inc. has already acted in reliance upon this authorization. My revocation may be submitted in writing to the Privacy Officer of Allied Eye Physicians & Surgeons, Inc.

_____ _____
Signature of Patient or Legal Guardian Date Signed

_____ _____
Print Name of Legal Guardian Guardian's Relationship to Patient

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<u>RECEIPT</u> – Notice of Privacy Practices

Allied Eye Physicians & Surgeons, Inc. respects your privacy and only uses or discloses your medical information when necessary or appropriate. Our Notice of Privacy Practices describes potential uses and disclosures of your health information by our practice and outlines your medical privacy rights.

Please sign below and give this form to the receptionist so we know you have received or seen online our Notice of Privacy Practices. Name/Signature of Personal Representative is only required in applicable.

Patient Name (please print): _____

Signature: _____ Date: _____

Name of Personal Representative (please print): _____

Signature of Personal Representative: _____ Date: _____