ERIN HECKMAN, O.D.

Disclosure of Protected Health Information (PHI) and Privacy Practices Acknowledgement

Name of Patient: ____

Date of Birth: ________________ Social Security Number: _____________________

Please list the names any persons/organizations you will allow us to release eye examination information (including all prescriptions) to, if necessary. Most commonly listed entities include parents, spouse, children, or other health care facilities outside the scope of optometric/medical practices. Only the person or persons listed below may receive any information about your appointments, account, exam, and/or prescriptions.

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We may use/disclose your PHI for the purposes of treatment, payment, and health care operations.

You may update your authorization at any time by adding or deleting names already listed.

I understand that, by signing this form, I am confirming my authorization for the use/disclosure of the PHI described in this form with the people and/or organizations named in this form.

I also acknowledge that I have received the Notice of Privacy Practices and have been provided with an opportunity to review it.

____ ________________

Signature of Patient or Parent/Guardian Date