WillsEye Physicians
Mid Atlantic Retina

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice of Privacy Practices for Mid Atlantic Retina.

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient Signature Date

AUTHORIZATION FOR ALTERNATIVE COMMUNICATIONS

If you would like us to send you email and/or leave detailed voice mails that contains your protected health information, please fill out the appropriate information below and sign below.

I authorize the use of the following communication methods when communicating with me and my authorized individual(s) (**fill in all that apply or circle decline):**

E-mail address that may be used to send information: _____ DECLINE

Phone number(s) for detailed voice mail: _____ DECLINE

_____ _____
Patient Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, children or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical and/or billing information released to family members you must sign below. Signing below will only give information to the family members indicated below.

I authorize Mid Atlantic Retina to release my medical, billing and/or appointment information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Patient Information

1. I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.
2. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.
3. You have the right to revoke this consent in writing.

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient/Legal Representative Signature Date