## ACKNOWLEDGEMENT OF ACCESS TO NOTICE OF PRIVACY PRACTICES

☐ I have received a copy of this office's notice of privacy practices.

☐ I have declined receipt of the notice of privacy practices.

## AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

If you sign this authorization, you can revoke it later. The only exception to this is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send a written notification to this office.

☐ You may release my health information to the following:

☐ Do not release my information to anyone

☐ Anyone who requests it

☐ Spouse_____

☐ Children_____

☐ Family Member _____

☐ Friend_____

Attn. Patient: If no block is checked, we cannot give any information to anyone. This includes letting someone pick up a prescription, glasses, contact lenses, etc.

Signature:_____ Date:_____