Central Arkansas Ophthalmology
Comprehensive Eye Care & Surgery

Acknowledgement of Receipt of Notice of Privacy Practices & Authorization Information

Patient Name: _____ Date of Birth:_____

I acknowledge that I have received the Notice of Privacy Practices on the date below on behalf of Central Arkansas Ophthalmology. I understand that the Notice of Privacy Practices describes the uses and disclosures of my Protected Health Information (PHI) by Central Arkansas Ophthalmology and informs me of my rights with respect to my PHI.

_____ _____
Signature of patient or personal/legal representative Printed name of patient or personal/ legal representative

_____ If personal/legal representative, indicate relationship_____
Date

I authorize Central Arkansas Ophthalmology to leave a detailed message on my voicemail regarding my personal and protected health information:

☐ Home phone_____ ☐ Work phone_____ ☐ Cell phone _____

Name of the person(s) and relationship that you are authorizing Central Arkansas Ophthalmology Associates to disclose your personal health information (PHI) to:

Name_____ Contact Number_(_____)_____

Relationship: ☐ Spouse ☐ Child ☐ Guardian ☐ Friend ☐ Other _____

Name_____ Contact Number_(_____)_____

Relationship: ☐ Spouse ☐ Child ☐ Guardian ☐ Friend ☐ Other _____

Please indicate the type of information you are authorizing to be used and disclosed to the above named person(s):

☐ Appointment scheduling ☐ Billing & payment arrangements ☐ Diagnosis, Treatment & Prescription Information
☐ Test results ☐ Call-back number only

THIS AUTHORIZATION MAY BE REVOKED OR RESTRICTED UPON YOUR REQUEST

Please review and update the authorization information annually. If no changes, please initial below.

Patient Initials:	Date:	Patient Initials:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INTERNAL OFFICE USE ONLY:
I attempted, but was unable to obtain the patient signature in acknowledgement of receipt of the Notice of Privacy Practices of Central Arkansas Ophthalmology. Date:_____ Staff:_____
Reason:_____