Edmond Family Eye Care

Permission for Disclosure of Protected Health Information

I, _____, give my permission for Edmond Family Eye Care to give information to the people listed below about my medical care. This information may include medications being taken, appointment times, changes in appointments, doctor reports about me, and any other information that this office has about me. (Please do NOT include other physicians or your employer in this list.) It is my responsibility to keep the office updated on any changes in my personal information.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

OPPORTUNITY TO OBJECT

I, _____, do not want any information given to anyone but myself regarding my healthcare status or other patient information.

I hereby acknowledge that I have access to a copy of the *Notice of Privacy Practices* for this medical office. I further acknowledge that I may request a copy of any amended *Notice of Privacy Practices* at each appointment.

___ Yes, I would like to request a copy of the *Notice of Privacy Practices*

___ No, I do not want a copy of the *Notice of Privacy Practices*

_____ _____

Signature of Patient/Personal Representative Date