HIPAA DOCUMENTATION

I acknowledge that I have been provided with the opportunity to read and/or receive a copy of Twin Tiers Eye Care Associates' Privacy Practices Policy.

CHOOSE ONE OF THE FOLLOWING, SIGN AND DATE BELOW.

_____ I authorize all information regarding my medical care (appointment time, eyeglass/pharmaceutical prescriptions, exam/test results, etc.) to be released to the following individuals, should they contact Twin Tiers Eye Care Associates.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

OR

____ I DO NOT authorize the release of my health information to anyone except for the purposes of medical care or payment, or to me personally.

I understand that I may revoke this authorization at any time, and in any event, it shall expire ten years from the date of this authorization.

Patient/Parent Signature:_____ Date:_____