

APPENDIX C
Garrett Eye Center

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of Garrett Eye Center's notice of privacy practices. This notice describes how Garrett Eye Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Signature of Patient or Personal Representative

Date

If you wish for us to share any information with your family or anyone other than another physician/office please fill out below and sign.

Release of Information:

I hereby give permission for doctors/staff at Garrett Eye Center to release my protected health information (Re: medications, appointment time, exam information, medical diagnosis, etc.) to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____