Central Arkansas LASIK

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:____

EDWARD M. PENICK III, M.D

Rev. 07/16