ATLANTIC EYE ASSOCIATES

Privacy Information Form

Please complete the following information and it will be added to your chart and will become a permanent part of your medical record. If you wish to revoke any of the following permissions or contact information your request must be made in writing. Upon approval of our Compliance Officer, your request will be effective immediately. If you have any questions please notify one of the staff members and they will be happy to assist you.

I ACKNOWLEDGE THAT I HAVE RECEIVED OR BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

_____ _____
Patient Signature Date

PLEASE CIRCLE:

I **authorize / do not authorize** employees or staff members to contact me by phone to notify me of upcoming appointments, test results, account information, and any other information regarding services provided to me by the Doctors of Atlantic Eye Associates with the following restrictions.

*** I understand that the privacy of my phone call cannot be guaranteed if I am using a cell phone or portable (cordless) phone.**

CHOOSE ONE OF THE FOLLOWING:

☐ **NO RESTRICTIONS** – I authorize any staff member of Atlantic Eye Associates to call or leave a message at home, work, etc. and to speak with anyone at those locations with any of the above referenced information.

☐ **LIMITED RESTRICTIONS** – I authorize any staff member of Atlantic Eye Associates to speak with myself or if I am not available to speak with only the following people as "Patient Representatives" with any of the above referenced information:

_____ _____
Name of Patient Representative (Please Print) Relationship to Patient

_____ _____
Name of Patient Representative (Please Print) Relationship to Patient

_____ _____
Name of Patient Representative (Please Print) Relationship to Patient

Please list below any other specific conditions or restrictions to the above information. (Example: Do not leave messages on machine/voice mail at home or work, etc. Please be very specific.)

_____

_____

☐ **TOTAL RESTRICTIONS** – I authorize any staff member of Atlantic Eye Associates to speak with myself only with any of the above referenced information.

_____ _____
Patient Name (Please Print) Date

_____ _____
Patient Signature Chart #