ATLANTIC EYE, LLC
HIPAA/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 from 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 I AM IN RECEIPT OF OR HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

_____ _____
Patient Signature Date

DISCLOSURE INFORMATION

CHOOSE ONLY ONE (1) OF THE FOLLOWING:

___ **NO RESTRICTIONS** – I authorize any physicians/staff of Atlantic Eye, LLC to call or leave a message at home, work, etc. and to speak with anyone at those locations regarding upcoming appointments, test results, account information or any other information pertaining to services provided by this practice.

___LIMITED RESTRICTIONS - I authorize physicians/staff of Atlantic Eye, LLC 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.

___TOTAL RESTRICTIONS – I authorize any physician/staff of Atlantic Eye, LLC to speak with myself ONLY regarding any of the above referenced information.

_____ _____
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/voicemail at home or work, etc. Please be specific.)_____

_____ _____
Patient Signature: Patient Name (Please Print):

_____
Date:

Office Use Only: Acct #_____