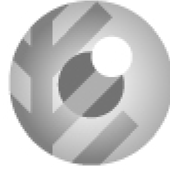

CAROLINA
EYE SPECIALISTS

Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

I ____ (please print patient name) have been provided a copy of Carolina Eye Specialists Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

It has been explained to me, the patient ____________________________that disclosures may be made to family and friends related to my health or as needed for payment of health care services. It has been explained to me that Carolina Eye Specialists will only disclose information relevant to current treatment and disclose health care information to: (check all that apply)

AUTHORIZED

(YES)	(NO)	
______	______	SPOUSE NAME____________________________
______	______	PARENT(S) NAME__________________________
______	______	PARENT(S) NAME__________________________
______	______	SIBLING(S) NAME__________________________
		OTHER:
______	______	____________________________________
______	______	____________________________________
______	______	____________________________________
______	______	____________________________________

____
Patient Signature

____
Date

____
Authorized Representative of Patient Relationship to patient