Hunter W. Chapman, OD

Release of Information & Privacy Policy Acknowledgement

Patient Name: _____

Release of Information

With my signature below, I authorize the release of information including the diagnosis, records, treatment recommendations to pharmacies, other health professionals, and claims information.

Please check either Box A or Box B:

☐**A** This information may also be released to:

- ☐ Spouse: _____
- ☐ Parent(s): _____
- ☐ Other legal guardian(s): _____
- ☐ Child(ren): _____
- ☐ Other: _____

☐**B** Information is not to be released to anyone.

Method of communication:

I authorize contact from this office to confirm my appointments, treatments, billing information, information about my health via:

☐ cell phone ☐ home phone ☐ work phone ☐ email ☐ text message to cell phone

☐ **any of the above**

The *Release of Information* will remain in effect until terminated by me in writing.

Signed: _____ Date: ___ /___ / ___

Privacy Policy Acknowledgement

How would you like to be addressed when summoned from our reception area?

☐ First name ☐ Proper Surname ☐ Either ☐ Other: _____

Due to potential danger to yourself and others, you are aware it may be hazardous to drive while your eyes are dilated, medicated, or patched.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

You have read and agreed with the Privacy Policy set forth by Dr. Chapman. With your signature, you acknowledge that should you have any requests or questions, you may direct them to our facility's Privacy Officer.

Signed: _____ Date: ___ /___ / ___

FOR OFFICE USE ONLY:

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

☐ it was emergency treatment ☐ I could not communicate with the patient ☐ the patient refused to sign

☐ the patient was unable to sign because / other: _____ Signature of Privacy Officer: _____