Authorization To Discuss Information/Dispense Materials to Family and/or Caregivers:

To comply with the HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your care with anyone else including your family, children, caregivers, etc. This authorization enables us to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person, the person(s) listed below.

If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below.

This authorization is optional and can be withdrawn by you at any time.

Name:____ Name:____

Relationship:__________________________________ Relationship:____________________________________

Phone:____ Phone:____

SIGNATURE:____ Date:________________________________

Emergency Contact Name & Phone:____

OFFER OF -OR- ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

I acknowledge that I was offered/or received a copy of Notice of Privacy Practices for the office of Pendleton Family Optometry, P.C.

Patient Name:____

SIGNATURE:____ Date:______________

Insurance Information

Name of Policy Holder:____

Policy Holder's Date of Birth:____

Policy Holder's Social Security Number:________________________________

Policy Holder's Employer:____