Acknowledgement of Notice of Privacy Practices
Betts and Biddle Eye Care PA

Print Name: ____

The law requires that Betts and Biddle Eye Care PA make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

_______ I was given the opportunity to read, have read or had explained to me Betts and Biddle Eye Care PA's Notice of Privacy Practice prior to any services offered.

_______ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

I authorize Betts and Biddle Eye Care PA to release my personal health information to the following individuals:

____

My insurance plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

_______ I authorize the release of medical information to my insurance plan

_______ I do not authorize the release of medical information to my insurance plan

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

____	______________________________
Patient Signature	Date

If you are signing as a personal representative of the patient, please indicate your relationship below. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

____	______________________________
Representative Signature	Relationship to Patient