HERITAGE EYECARE
TODD A PAGE, OD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You may refuse to sign this acknowledgement.

I, ________________________________have received a copy of this office's Notice of Privacy Practices.

Signature____Date_________________________

Heritage Eyecare respects your privacy and the confidentiality of your medical records. We will not release information to persons or organizations without your written consent. Please sign if you consent on the items below. Consent can be revoked in writing at anytime.

1. I give permission for Heritage Eyecare to send my **recall postcard** by mail. These postcards will include my name, address, last eye examination date and recall date.

2. I give permission for Heritage Eyecare to release my **spectacle and/or contact lens** prescription to optician or dispensaries by mail, telephone or fax when I request that release.

3. I give permission for Heritage Eyecare to share my medical/personal information with **insurance companies or financial institutions** in order to submit claims and process payment by mail, electronic, or telephone.

4. I give permission for Heritage Eyecare to share my medical information with my **primary care physician** and physician(s) to whom I am referred to by letter, fax or telephone.

5. I give permission for Heritage Eyecare to share my medical information with **optical laboratories, contact lens manufactures and/or distributors** in order to fabricate spectacle corrections or obtain contact lenses.

6. I give permission for Heritage Eyecare to share my medical information with a **pharmacy** by fax or telephone to order pharmaceutical prescriptions.

7. I give permission for Heritage Eyecare to discuss my medical information with this/these person(s):

Signature____Date_________________________