Receipt of Notice of Privacy Policies, Consent, and Release of Health Form

Dr. Gary H. Greene / Ironwood Eye Care
10149 N 92ndSt., Ste. 102, Scottsdale, AZ 85258
(Office) 480-860-1330 (Fax) 480-391-9303
(E-Mail) info@ironwoodeyecare.com

I acknowledge that a copy of this offices Notice of Privacy Practices has been make available to me. I consent to the use and disclosure of the health information for purposes of treatment, payment, and healthcare operations regarding the patient listed below.

Please check one box below and sign/date below

☐ **I DO authorize** the persons listed below to receive protected health information or materials on my behalf

☐ **I DO NOT authorize** any information or materials released to any persons on my behalf.

____
Full Name Relationship Date

____
Full Name Relationship Date

____
Full Name Relationship Date

____
Full Name Relationship Date

(Any persons not listed above will be considered unauthorized and we will be unable to supply information to them)

X______________________ ______________________ ____________
SIGN Patients Name, Parent/Guardian (if under 18), PRINT Patient Full Name Date

Or Personal Representative

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

______________________ ______________________
Relationship to Patient Print Name

Source of Authority: ____

in office use only

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ *Individual refused to sign*

☐ *Communication barriers prohibited obtaining acknowledgement*

☐ *An Emergency situation prevented us from obtaining acknowledgement*

☐ *Other (please specify)*