



# CENTER FOR SIGHT

Center For Sight, P.L. and Laser & Surgical Services at Center For Sight, LLC (CFS)

## PATIENT ACKNOWLEDGEMENT AND AUTHORIZATION

### Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received, and have had the opportunity to ask questions regarding, a copy of the Center For Sight Notice of Privacy Practices.

Patient's / Patient's Legal Representative Name (print): \_\_\_\_\_

Patient's / Patient's Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by Representative, state relationship to patient: \_\_\_\_\_

### Authorization to Release Protected Health Information (PHI)

I hereby authorize Center For Sight to release my PHI to the following person(s) and understand that I may revoke this authorization in writing at any time. I understand that such disclosures may include, but not be limited to, discussing my medical condition(s) and treatment(s) with individuals that accompany me to my appointments and / or are responsible for my care-giving, leaving voice mail messages regarding appointments and / or balances due on my account, and any emergency situation which may arise in the course of my care.

\_\_\_\_\_  
Name of Authorized Person                      Relationship                      Daytime Phone Number

\_\_\_\_\_  
Name of Authorized Person                      Relationship                      Daytime Phone Number

\_\_\_\_\_  
Name of Authorized Person                      Relationship                      Daytime Phone Number

Patient's / Patient's Legal Representative Name (print): \_\_\_\_\_

Patient's / Patient's Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by Representative, state relationship to patient: \_\_\_\_\_

### Documentation of Good Faith Efforts ~ to be completed if patient unable or unwilling to sign Acknowledgement

On this day, patient presented for treatment and was provided a copy of the CFS Notice of Privacy Practices. Although a good faith attempt was made to obtain a written Acknowledgement of Receipt and Authorization to Release, signatures were not obtained because:

\_\_\_\_\_ Patient / Legal Representative refused

\_\_\_\_\_ Patient / Legal Representative unable due to medical disability

\_\_\_\_\_ Emergency medical condition required immediate attention (signature to be obtained at next appointment)

\_\_\_\_\_  
Name of CFS employee

\_\_\_\_\_  
Signature of CFS employee

Date \_\_\_\_\_