Ohio Eye ASSOCIATES

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NOTICE OF BILL OF RIGHTS, ADVANCED DIRECTIVES, PRIVACY PRACTICES AND RELEASE OF INFORMATION ACKNOWLEDGEMENT

I have received or was offered a copy of Ohio Eye's Notice of Bill of Rights, Advanced Directives, and Privacy Practices and understand that my protected health information may be used by the practice as described in the notice.

Ohio Eye is authorized to release information to the following person(s):

Name _____ Relationship _____

Name _____ Relationship _____

☐ I do not authorize release of information to anyone at this time.

_____ _____

Patient Printed Name Date of Birth

_____ _____

Patient Signature Date