ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have been given the opportunity to read and receive a copy of Tri-State Centers For Sight, Inc.'s Notice of Privacy Practices ("Notice").

Date_____

Signature (Patient or Authorized Representative)_____

Printed (Patient or Authorized Representative)_____

FOR OFFICE USE:

If you are unsuccessful in obtaining a signature from the patient or authorized representative explain circumstances below.

_____

Signature Staff Member_____Date _____

AUTHORIZATION FOR THE USE OR RELEASE OF HEALTH INFORMATION

I authorize Tri-State Centers for Sight, Inc to release **(circle type of information) Financial Medical All**

my protected health information to (persons or person)_____
_____.

This Authorization shall expire on _____ year_____

I understand that I have the right to cancel this Authorization, if the cancellation is in writing, except if

- Tri-State Centers For Sight, Inc. has already released information prior to cancellation.
- The cancellation must be in writing to the address listed below.

I understand that my medical and account information that is used or released under this document may be subject to re-use by the person or persons receiving the information, and the privacy of my medical and account information will no longer be protected by the law.

Treatment cannot be withheld for refusing to sign this authorization unless the following is true:

- The reason for the exam and authorization is to be included in a medical research study, or
- The sole purpose of the exam is to send a third party the results of the exam after obtaining this agreement. For Example An employer requested exam for prospective employees, or a school exam.

Messages with ☐ medical ☐ financial information may be left on voice mail at the following number(s).

☐ home phone _____ ☐ cell phone _____

☐ work phone _____ ☐ none of the above

By signing this agreement, I acknowledge that I have read and understand the terms. Further, I authorize the use or release of my medical and account information (Protected Health Information) in accordance with the terms of this Agreement.

_____
Signature (Patient) Date

_____
Printed

_____
Signature (Witness) Date

_____
Signature (Authorized Representative) Date

Description of Authorized Representative's
authority to sign for the patient:_____

For cancellation in-whole or in-part write to:
HIPAA Contact Person
Tri-State Centers For Sight, Inc.
802 Scott Street
Covington, KY 41011