Susanne M. Hewitt, MD
Richard E. Parè, MD
Parvathi Rayudu, MD

North Fulton Eye Center - Cumming Eye Clinic

AUTHORIZATION TO RECEIVE/RELEASE PATIENT HEALTH INFORMATION "PHI"

HIPAA compliance privacy laws of the Federal Government requires that we ask you to review and answer the following questions listed below. Thank you!

Patient Name: ____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

_______ Yes _________ NO Home Phone #______________________________________

_______ Yes _________ NO Cell #______________________________________

Do you have any particular person (friend or family member) that you authorize to receive and discuss information regarding your PHI (general information, surgical & billing information)?

_______ Yes _________ NO Name____

Relationship: ______________________________________ Phone Number: _________________________

Alternate Phone Number: ____________________________________

Is this person your Power of Attorney for medical purposes? _______ Yes _________ NO

Acknowledgement of Receipt of Privacy Practices

I hereby authorize **North Fulton Eye Center-Cumming Eye Clinic** to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my on-going treatment to or from other healthcare providers, laboratories or medical institutions. This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues listed above.

I have reviewed **North Fulton Eye Center-Cumming Eye Clinic** Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

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Patient/Guardian Date