Morristown Ophthalmology Associates, P.A.
131 Madison Ave., Suite 130
Morristown, NJ 07960

Acknowledgment of Receipt of Privacy Practices

By my signature below, I acknowledge that I have received Morristown Ophthalmology Associates, P.A. Notice of Privacy Practices.

Name: (PRINT) ___________________________________

Signature: _______________________________________

Date: ____

Permission To Release Your Sensitive Information

I, ________________________, give permission for Morristown Ophthalmology Associates, P.A., including the doctors and staff, to speak with the following people about my protected health information (test results, today's appointment, entire medical record, insurance information, billing information, etc.):

Name: ___________________________________ Relationship____________________________

Name: ___________________________________ Relationship____________________________

Name: ___________________________________ Relationship____________________________

Please Circle:

Is there any information that you would like to be withheld from those listed above? Yes No

If so, what information? ____

Do we have permission to leave detailed voice messages, possibly including sensitive health or billing related information on your phone number(s)? Yes No

Note: This consent will be in effect until it is revoked in writing.

Signature: ____

OR Signature of Parent/Legal Guardian: ____

Date: ____