

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.

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: _____