SCOTTSDALE EYE PHYSICIANS & SURGEONS, P.C.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I, ___________________________________, acknowledge that the Patient Privacy Notice has been made for my review. The Notice describes how Scottsdale Eye Physicians & Surgeons, P.C. may use and disclose my protected health information, certain restrictions on the use and the disclosure of my healthcare information, and rights I may have regarding my protected health information.

___________________________________ ____________________
(Signature of Patient or Guardian) (Date)

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(Relationship to Patient)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize and agree that Scottsdale Eye Physicians & Surgeons, P.C. may disclose my protected health information to parties already allowed by the Privacy Act (e.g. insurance company, etc.). I also authorize disclosure to the following persons set forth on this form, unless and until I object to such disclosures, which must be provided in writing to Scottsdale Eye Physicians & Surgeons, P.C.

1. ________________________________ 3. ________________________________

2. ________________________________ 4. ________________________________