PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____ DOB: _____

Signature_____ Date: _____

I hereby authorize the release of my information:

To: _____
(Spouse, relative or friend)

_____ _____
(Relationship) (Phone #)

Please initial <u>which</u> information you would like released to this person:

_____ Medical information ONLY _____ Billing/financial information ONLY
Initials Initials

_____ Both medical and billing/financial information
Initials

ALTERNATIVE CAREGIVER CONSENT FOR MINORS/POA

***Except for life threatening emergencies, we are not able to treat the above mentioned patient unless he or she is accompanied to our office by a parent, legal guardian, POA or designated adult. In order to designate an adult to bring the above mentioned patient to our office for medical/vision care in your absence, you must have the below information completed, signed and on file for each designated adult. The patient reporting for an appointment without parent, legal guardian and/or adult named in a signed designee form or a signed note from the parent will be rescheduled.**

I authorize the following individual(s) to bring the above mentioned patient to his/her appointments with Antietam Eye Associates

Name_____ Relationship to above mentioned patient_____

Name _____ Relationship to above mentioned patient_____

***I attest that the above named individual(s) are all 18 years of age or older as of this date and the capacity to consent to medical care. I authorize the above named individual(s) to consent treatment for the above mentioned patient. This may include, but not limited to, consent for necessary medications, dilation, and procedures/testing. This practice may relay any medical information about the patient necessary for the above named individual(s) to provide informed consent to his/her treatment.**

***I understand that the doctor will communicate his/her findings and treatment to the caregiver who brings in the patient, and that under most circumstances, a follow up call to me personally should not be necessary.**

***I agree to hold Antietam Eye Associates and its staff harmless for any disagreement between the above named individual(s) and myself regarding treatment.**

***I attest that I am the parent, legal guardian or POA of the above mentioned patient and that I have the legal authority to make the agreement. I understand that I can revoke this authorization for any of the above mentioned individual(s) at any time.**

_____Signature of Parent, Legal Guardian or POA_____Date

This release will remain in effect until changed in writing.