AAPECS Atlantic Eyecare

Robert Seim OD, PC
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HIPAA Notice of Privacy Practices Acknowledgment

I, the undersigned, acknowledge that I have been advised that the Notice of Privacy Practices pamphlet for AAPECS Atlantic Eyecare is available at the front desk.

PATIENT NAME:_____________________________________**BIRTH DATE**:___________
(Please Print)

Patient
Signature:______________________________________

Date:____

If patient is unable to sign, or, you are signing as the personal representative of the patient:

Personal representatives Name:______________________________________
(Please Print)
Relationship to Patient:____

Signature:_____________________________________Date:______________

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION to any physician, health care facility, insurance carrier or agency is hereby given to the Doctors of AAPECS Atlantic Eyecare.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION to AAPECS Atlantic Eyecare is also given to any other physician, health care facility or when medical records are requested for the purpose of continued medical care by the Doctors of AAPECS Atlantic Eyecare

Authorization is effective until revoked by the patient.

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If you would like us to release your medical information to any person other than yourself or those authorized under HIPAA, please indicate below:

Name of authorized person to receive your Protected Health Information:

Name:_________________________Relationship:____________________

Name;_________________________Relationship:____________________

Name:_________________________Relationship:____________________