MITCHELL
FAMILY EYE CARE

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I hereby acknowledge that I have received a copy and/or read the (HIPPA) Health Insurance Portability and Accountability Act.

_____
(printed name)

_____ _____
(signature) (date)
(parent or legal guardian, if minor)

PERMISSION TO RELEASE MEDICAL RECORDS

I _____, hereby give permission to release any and all medical information obtained during the course of any examinations to the following individual(s):

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

Signed:_____ Date:_____