

WESTERN WAKE EYE CENTER, P.A.

• **CONSENT TO LEAVE MEDICAL INFO WITH SOMEONE OTHER THAN THE PATIENT**

I am authorizing the personal at Western Wake Eye Center, P.A. to leave information related to my care with others if I am not available. Check all that apply:

____ I authorize that information can be left with my wife/husband/significant other.
Name of person _____

____ I authorize that information can be left on my answering machine (phone) _____

____ I authorize that information can be left on my voice mail (phone) _____

____ Other; I authorize that information can be left _____

I understand that this authorize will be valid until I give written notification otherwise.

• **NOTICE OF PRIVACY PRACTICES; WRITTEN ACKNOWLEDGEMENT FORM**

I _____ understand the Notice of Privacy Practices. The Notice provides WESTERN WAKE EYE CENTER, P.A. the disclosures and uses of my protected health information.

Signature of Patient

Date

Patient Personal Representative

Date

Relationship to Patient (if signed by a personal representative of patient): _____

Witness

Date