

Pt. # _____

RELEASE OF MEDICAL INFORMATION

May we give your test results or eye condition to a family member if you are not available?

YES ____ NO ____

If Yes, please list the name below:

_____ Spouse ____ Other _____

May we leave test results on your answering machine? YES ____ NO ____

**ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

Millman-Derr Center for Eye Care, P.C.
M.D. Surgicenter
M.D. Eye Center
M.D. Optical, Ltd.
M.D. Optical, Warren

By signing below, I acknowledge that I have received a copy of Notice of Health Information Practices form.

Patient Signature

Date