Acknowledgement of Receipt

I acknowledge that I have received a copy of Woodbine Eye Care's Notice of Privacy Practice.

Patient's Name: _____

Signature: _____ Date:_____

Medical Information Release Form

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/_____