

**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: \_\_\_\_\_

I acknowledge that once my contact lens prescription is finalized, it is available for me to download on my patient portal at my convenience. Initials: \_\_\_\_\_

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_