

HIPAA PATIENT NOTICE

It is our policy not to release confidential and/or unauthorized information on a home telephone, answering machine, work telephone, voice mail, or cell phone. When returning phone calls, we will not leave a detailed message on an answering machine if the identifying name or telephone number is not stated in the recorded message. We will not leave information with an unauthorized person who may answer the telephone. If you would like information released to someone other than yourself, please complete the following:

I authorize Associated Ophthalmologists of Kansas City, PC to leave detailed medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever the information changes.

Home telephone	yes	no
Answering machine	yes	no
Work telephone	yes	no
Cell phone	yes	no
Voice mail	yes	no

I hereby authorize Associated Ophthalmologists of Kansas City, PC to disclose appointment times, treatment, and test results (protected health care information) to the following people:

Name _____ Relation _____ Phone # _____
Address _____

Name _____ Relation _____ Phone# _____
Address _____

Name _____ Relation _____ Phone# _____
Address _____

Name _____ Relation _____ Phone# _____
Address _____

Signature Patient/Guardian

Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of AOKC Notice of Privacy Practices.
Patient Name