Anstadt Proctor

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# Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the physician's
(Patient's Name)

Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at my request.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient

_____.

– Patient's file

# GOTTLIEB EYE CENTER

# ANSTADT / PROCTOR

## Authorization Form for Release of Protected Health Information

I give permission for Drs. **Anstadt, Proctor, Tennenbaum or Swetland,** and their staff to speak with the following people regarding my medical condition and treatment and also my appointments or billing information:

| Name | Relationship | Phone Number |
|---|---|---|
| Name | Relationship | Phone Number |

Any detailed messages regarding appointments, medications, glasses or contacts **MAY** be left on my answering machine or cell phone or other designated phone number.

| Home Phone | Cell Phone | Other |
|---|---|---|

I understand that this authorization is valid until revoked or changed by written notice, and will be kept with my medical records.

| Patient or legal guardian if minor | Date |
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