PATIENT PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I ____give permission to the following person(s) to be given protected health information about myself, and/or talk to Singleton Vision Center about my billing, financial or health insurance information.

Date	Name	Relationship to patient

Your Rights as a Patient

- **I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the HIPAA Coordinator at Singleton Vision Center. I understand that a revocation is not effective in cases where the information has been disclosed by will be effective going forward.**
- **I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state laws.**
- **I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing this document. This authorization shall be in effect by me (the patient) or my representative.**

____ _____________________________

Signature of patient / Patient's Personal Representative *Date signed*

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I ____________________________________acknowledge that I have been given the Privacy Practices of Singleton Vision Center.

____ _______________________

Patient Signature / Patient's Personal Representative *Date signed*

FOR OFFICE USE ONLY

- Patient refused to sign for or to be given the Privacy Policy.
- Patient is unable to sign for or take Privacy Policy for this reason: ____________
- An emergency existed and signature was not possible at the time.
- A copy was mailed with a request for signature by return mail.

By: ____ ____________________

Employee Signature *Date*