

**ACKNOWLEDGMENT  
(OF RECEIPT OF NOTICE OF PRIVACY PRACTICES)**

I hereby acknowledge that a copy of Alta View Eye Care Clinic's Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about Alta View Eye Care Clinic's privacy practices or my rights with regard to my personal health information, I may contact the Office Manager for further information.

\_\_\_\_\_  
Please Print Name of Patient and Patients Representative, if one)

\_\_\_\_\_  
Signature of Patient (or Patient's Representative)

\_\_\_\_\_  
Date

Relationship to Patient:    Father        Mother        Guardian        Self        Other \_\_\_\_\_

**HEALTH INFORMATION AUTHORIZATION FORM**

**A. I hereby authorize the use or disclosure of my protected health information as described below and understand and acknowledge the following:**

- I am not required to sign this authorization and may in fact, refuse to sign this authorization. **Alta View Eye Care Center** will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law.
- If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected. I may inspect or copy the protected information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
- I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to **Alta View Eye Care Center**. If I do revoke this authorization, however, my revocation will not affect any prior action taken in reliance on my authorization.
- If I have any questions about this authorization, I may contact **Kathy Siskin at (801) 572-0631**, who will provide me with more information about this authorization, or about **Alta View Eye Care Center's** privacy practices.

Initials: \_\_\_\_\_

**B. Please print full name of those persons or organizations authorized to receive, disclose of or use your protected health information identified above.**

\_\_\_\_\_  
\_\_\_\_\_

**C. Please provide a specific description of your health information to be used or disclosed (identification, including dates).** \_\_\_\_\_

\_\_\_\_\_

**D. This authorization will expire on (date)** \_\_\_\_\_ **; or upon the following event** \_\_\_\_\_

\_\_\_\_\_

**I certify that I have read, signed and received a copy of this authorization.**

\_\_\_\_\_  
Signature of Patient (or Patient's Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Patient Representative to Patient

\_\_\_\_\_  
Date