

**NOTICE OF PRIVACY PRACTICES**

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Effective date of notice: September 1, 2013

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**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

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I authorize the professional office of my optometrist named above to release health information about me to the following persons:

<u>NAME</u>	<u>RELATIONSHIP</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**PATIENT NAME (Printed):** \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

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