Pocono Eye
Associates, Inc.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I acknowledge that I have received the Notice of Privacy Policies for Pocono Eye Associates

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient/Legal Representative Signature Date

CONSENT TO RECEIVE TEXT MESSAGES

Unless otherwise notified in writing, I consent to receive appointment reminders via text message from Pocono Eye Associates or from a third-party vendor contracted on their behalf: _____
Cell Phone

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient/Legal Representative Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, children or others to call and request medical or billing information. Under the requirements of HIPAA we are not permitted to release information to anyone without the patient's consent. **If you wish to have your medical and billing information released to family members, you must sign below**. Signing below will only give information to the family members identified below.

I authorize Pocono Eye Associates to release my medical, billing and appointment information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Patient Information:

1. I understand I have the right to revoke this authorization at any time by written request to Pocono Eye Associates
2. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient

_____ _____
Patient/Legal Representative Signature Date