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Ophthalmology
Specializing in Consultation, Management, and
Laser Surgery for Adult Glaucoma

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO COMMUNICATE PERSONAL HEALTH INFORMATION

I, (print name) _____, have received and read the NOTICE OF PRIVACY PRACTICES OF Robert A. Schumer, M.D., Ph.D. and HUDSON VALLEY GLAUCOMA CARE concerning the use or disclosure of Protected Health Information by the practice.

_____ _____
patient signature date

I hereby authorize the following individuals (for example: a spouse, or a friend) to receive communications (such as lab results, scheduling of appointments), regarding my personal health information, on my behalf:

1. _____ relationship: _____

2. _____ relationship: _____

_____ _____
patient signature date

I hereby authorize Robert A. Schumer, M.D., Ph.D. and/or HUDSON VALLEY GLAUCOMA CARE, P.C. to leave messages for me regarding my personal health information on my home telephone answering machine.

_____ _____
patient signature date

_____ has refused to sign the RECEIPT OF NOTICE OF PRIVACY PRACTICES.

Employee name: _____

_____ _____
employee signature date