M. Patrick Day, O.D., P.C.
Clinton Vision Source

565 S 30th St.
Clinton, OK 73601
(580) 323-5421

M. Patrick Day, O.D., F.A.A.O.
Randi L. Day, O.D.

Patient Name:_____DOB:_____

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I received or was offered a copy of the Notice of Privacy Practices for M. Patrick Day, O.D., P.C.

Authorization for Disclosure of Health Information

I authorize my medical records and health information to be released, disclosed or discussed with the individuals listed below. DO NOT list doctors or parents/legal guardians of minors.

Name:_____Relation:_____

Name:_____Relation:_____

Name:_____Relation:_____

Name:_____Relation:_____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office of M. Patrick Day, O.D., P.C. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. I authorize the release of any information necessary to process insurance claims.

X_____ _____
Signature of patient or legal representative Date

I understand that there is a financial policy enforced by Clinton Vision Source. I understand that I have a right to request and obtain a copy of this policy at any time. I agree to abide by the financial policy.

X_____ _____
Signature of patient or legal representative Date

Please sign both signature lines