

# Lehigh Valley Center for Sight, P.C.

## PATIENT ACKNOWLEDGEMENT

You are not obligated to sign this form!  
This form does not affect your care or visit today!

In compliance with the requirements of the HIPAA Standards for Privacy of Individually Identifiable Health Information, Lehigh Valley Center for Sight, P.C. has adopted a Privacy Policy. We have always strived to protect your privacy in the past. By federal regulation we have instituted a written Policy, which is available upon request or can be found posted in the lobby.

## PATIENT AUTHORIZATION

I hereby authorize the use and disclosure of my individually identifiable health information to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in my care or payment related to my care. You may also notify family members or others involved in my care to inform them of my location or condition. I understand that this authorization is VOLUNTARY and may limit it in writing at any time.

I understand that this authorization will expire on 12/31/2099.

I understand I may revoke this authorization at any time.

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

\_\_\_\_\_  
Date

Printed Name of Patient's Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_