WESTERN WAKE EYE CENTER, P.A.

CONSENT TO LEAVE MEDICAL INFORMATION WITH SOMEONE OTHER THAN THE PATIENT

I am authorizing the personnel at Western Wake Eye Center, P.A. to leave information related to my care with others if I am not available. Check all that apply:

_____ I authorize that information can be left with my wife/husband/significant other.
Name of person ____

____ I authorize that information can be left on my answering machine (phone) _________

____ I authorize that information can be left on my voice mail (phone) _______________

____ Other; I authorize that information can be left_____________________________
____

I understand that this authorization will be valid until I give written notification otherwise.

- **NOTICE OF PRIVACY PRACTICES; WRITTEN ACKNOWLEDGEMENT FORM**

I ____________________________________ understand the Notice of Privacy Practices. The Notice provides WESTERN WAKE EYE CENTER, P.A. the disclosures and uses of my protected health information.

_____________________________________ _________________________
Signature of Patient **Date**

_____________________________________ _________________________
Patient Personal Representative **Date**

Relationship to Patient (if signed by a personal representative of patient) _______________

_____________________________________ _________________________
Witness **Date**