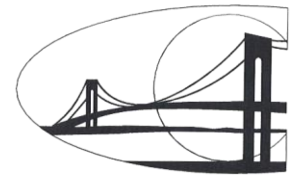

ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

1. Acknowledgment of Privacy Practice Notice

   A copy of Ophthalmology Associates of Staten Island's Notice of Privacy has been made available for me to' review.

   Patients Name: ______________________________ Date of Birth ____________________

   Signature of Patient/Parent/Guardian: _____________________Date: _________________

2. Designation of certain Relatives. Close Friends and Other Caregivers

I agree that Ophthalmology Associates of Staten Island may disclose certain of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Ophthalmology Associates of Staten Island will *disclose only information that is directly relevant to the person's involvement with my health. care or payment relating to my health care.*

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Ophthalmology Associates of Staten Island's making the limited disclosures described above. I understand that I am not required to list any one. I also understand that I may change this list at any time in writing.

Print Name: __________________________________ Relationship ____________________

Print Name: __________________________________ Relationship ____________________

Print Name: __________________________________ Relationship ____________________

Signature of Patient/Parent/Guardian: ____________________ Date ___________________