I acknowledge that I have received the “Notice of Privacy Practice” from Westwood Ophthalmology Associates, P.A.

Print Patient’s Name ______________________________ Date ____________________

Signature of Patient and/or Legal Guardian ______________________________________

Print Legal Guardian’s Name ____

Consent to Release Information:

By signing below, you permit Westwood Ophthalmology Associates, P.A. to release any medical information to the physicians involved in your care. You consent that this practice may call you at home or other designated locations and leave a message on your answering machine, voice mail or in person in reference to appointment reminders and insurance items. In addition, this practice may mail to your home appointment reminder cards and patient statements.

You designate the following representative(s) who Westwood Ophthalmology Associates, P.A. can communicate with on your behalf. If you do not designate anyone, the doctor will not be able to speak to anyone in your family regarding your medical condition.

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Name Relationship

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Name Relationship

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Name Relationship

Print Patient’s Name __________________________________ Date _________________

Signature of Patient and/or Legal Guardian ______________________________________

Print Legal Guardian’s Name ______________________________________