alterman, modi & wolter
seeta eye centers
GENERAL, MEDICAL, SURGICAL & LASER EYE CARE

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have received a copy of the Notice of Privacy Practices for the office of:
Morton A. Alterman, M.D.
Satish S. Modi, M.D., F.R.C.S. (C)
Andreas Wolter, M.D.

______________________________ ______________________
Signature of Patient/Guardian Date

______________________________ ______________________
Printed Name of Patient/Guardian Date

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Patient Authorization for the Release of Health Information

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I hereby authorize the personnel at the office of Morton A. Alterman, M.D., Satish S. Modi, M.D., and Andreas Wolter, M.D. the use or disclosure of my individually identifiable health information. I understand that this authorization is voluntary. I understand that if my information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

Please note, even if you do not sign this authorization, Morton A. Alterman, M.D., Satish S. Modi, M.D., and Andreas Wolter, M.D. and their authorized personnel may release information to other physicians, optometrists, or healthcare professionals at their discretion in order to facilitate your medical treatment.

_______________I understand that my health care and payment for my health care will not be affected if I do not sign this form.
_______________I understand that I may see and copy the information described on this form if I ask for it.
_______________I understand that I may revoke this authorization at any time by notifying the Practice in writing. If I do revoke it, the revocation will not have any affect on any actions the Practice took before it received the revocation.
_______________I understand this authorization will not expire unless I specify a date.

Signature of Patient: ______________________________ Date: ____________________

Printed Name: ____