**Craig. A. Cassey, O.D., P.C. & Associates**

4590 Edgmont Avenue

Brookhaven PA 19015

610-872-6077

139 S. State Road

Springfield, PA 19015

610-543-8200

The law requires that Craig. A. Cassey, O.D., P.C. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

\_\_\_\_I was given the opportunity to read, have read or had explained to me Craig. A. Cassey, O.D., P.C.'s Notice of Privacy Practice prior to any services offered.

\_\_\_ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

I authorize Craig. A. Cassey, O.D., P.C. to release my personal health information to the following individuals:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

\_\_\_ I authorize the release of medical information to my vision plan

\_\_\_ I do not authorize release of medical information to my vision plan

Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy.

\_\_\_ I authorize the use of standard email, in spite of the known risk involved, to communicate with me.

\_\_\_ I do not authorize the use of standard email to communicate with me.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Representative Signature Relationship to Patient