VICTOR A. CROSBY, M.D.
OPHTHALMOLOGY

NOTICE OF PRIVACY PRACTICES:

ACKNOWLEDGEMENT OF RECEIPT

By signing this form you acknowledge you have had the opportunity to view the *Notice of Privacy Practices of Victor A. Crosby, M.D., l*ocated in our lobby. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Should you like a copy, please ask the receptionist and we will be happy to provide you with a copy.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting the office at 706-546-0170.

Should you have any questions regarding the *Notice of Privacy Practices*, please contact our office at 706-546-0170.

I acknowledge receipt of the *Notice of Privacy Practices of Victor A. Crosby, M.D.*

Signature:_____ Date:_____
(patient/parent/conservator/guardian)

CONSENT FOR DISCLOSURE TO FAMILY MEMBERS OR PERSONAL REPRESENTATION

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission to Dr. Crosby and his staff to disclose my personal medical and financial information to the following individual(s). (This includes discussion of account information, making of appointments, prescriptions concerns, etc.)

Names: _____ Relationship:_____

Names: _____ Relationship: _____

Names: _____ Relationship: _____

Conditions for Disclosure (check the item(s) that apply):

----- The practice may disclose information to the individual(s) above **only** in my presence.

----- The practice may disclose information to the individual(s) above in discussion in my presence and when I am not physically present, including disclosures by telephone, facsimile, or mail.

----- Other conditions:_____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual(s) acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why the acknowledgment was not obtained:

Signature of provider representative: _____Date:_____

_____