WEST GEORGIA EYE CARE CENTER

The Region's Multispecialty Eye Care Provider

"*Commitment to Excellence – Spirit of Service*"

Affix Patient Label Here

AUTHORIZED PATIENT NOTIFICATION LIST

(Required of HIPPA) Health Insurance Portability and Accountability

I authorize all West Georgia Eye Care Physicians and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my care, to include: appointments, tests, test results, surgical procedures, prescriptions, charges and payments, and any other pertinent information pertaining to my care with the following designated people:

_____ _____

_____ _____

_____ _____

This document will be a part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorized Notification List.

_____ _____

PATIENT/OTHER PERSON AUTHORIZED TO SIGN DATE

_____ _____

RELATION TO ABOVE SIGNED DATE

_____ _____

WITNESS SIGNTURE DATE