HIPAA AUTHORIZATION FORM

Patient Name: (PRINT) _____

Patient Birthdate: _____

_____ By initialing this line, I acknowledge that I have received and/or read a copy of the North Dakota Eye Clinic Notice of Privacy Practices.

HIPAA Approved Contacts:

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone: _____

Relationship: _____

Patient Signature: _____

Today's Date: _____

*** Authorizations are valid for one year ***