HIPPA ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Skyline Family Eyecare / Eileen M. Curtin, OD's *Notice of Privacy Practices.*

Patient Name _____

Guardian Name _____

Signature _____ Date _____

AUTHORIZATION AND RELEASE

I hereby assign and direct my insurance benefits to be paid directly to Skyline Family Eyecare / Eileen M. Curtin, OD. I acknowledge that I am financially responsible for any non-covered services. I also authorize the release of any medical information acquired in the course of my examination or treatment.

Signature _____ Date _____