Andover Eye Associates, Inc.

Notices of Privacy Practices Acknowledgement and Consent

By signing below, I acknowledge that I have been provided a copy of the Andover Eye Associates, Inc. Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of the Notice, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

I authorize Andover Eye Associates, Inc. to release my personal health information to the following individual(s):

You may list as many individuals as you wish. Please print.

_____ _____
_____ _____
_____ _____
_____ _____

I understand that I may change this list at any time.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Each doctor is independent. Andover Eye Associates, Inc. is a billing and administrative agency.