

**NOTICE OF PRIVACY PRACTICES**

**Weigel Family Eye Care, Optometrists, P.C.  
223 East Washington St., P.O. Box 167  
Greensburg, IN 47240  
812-663-2480  
Fax: 812-662-0486  
Office contact: Dr. Weigel**

Effective date of notice: September 1, 2013

---

---

**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

---

---

I authorize the professional office of my optometrist named above to release health information about me to the following persons:

<u>NAME</u>	<u>RELATIONSHIP</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**PATIENT NAME (Printed):** \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_