ANNE ARUNDEL
Eye Center
Cataract & Glaucoma Specialist

By signing this form, you acknowledge receipt of our Notice of Privacy Practices. Our Privacy Practices provides information about the ways in which we may use and disclose your protected health information. We encourage you to review it carefully. We would like you be able to communicate with you via email about your personal health information (PHI).

Your signature will allow us to email the address you provided with medical information regarding your patient care.

_____ _____

Printed name of Patient or Guardian Date

_____ _____

Email Address Signature of Patient or Guardian

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